

M

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 832

| | | | |
|--|-------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH - COUNTY <u>Wicomico</u> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Wicomico</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u> | | STREET ADDRESS (If rural, give location) <u>1301 N. Division St.</u> | |
| 3. NAME OF DECEASED (Type or Print) (First) <u>Harry</u> (Middle) <u>Covington</u> (Last) <u>Adkins</u> | | 4. DATE OF DEATH (Month) <u>January</u> (Day) <u>14</u> (Year) <u>1951</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>Jan. 10, 1886</u> |
| 9. AGE last birthday <u>65</u> yrs. | | 10. AGE last birthday If under 1 year Months Days If under 24 hrs. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retail Storeman</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>General</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Alpha Stanton Adkins</u> | | 14. MOTHER'S MARRIED NAME <u>Winnie Edgeman</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>VI4-10-91Y3</u> | |
| 17. INFORMANT AND ADDRESS <u>Mrs. Willa L. Adkins</u> | | | |

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Congestive Heart Failure

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Carcinoma Bronchogenic

(c)

INTERVAL BETWEEN ONSET AND DEATH

1 week(?)11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

| | | | | |
|--|---|-----------------------|----------|---------|
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> | HOW DID INJURY OCCUR? | | |

22. I hereby certify that I attended the deceased from April 17, 1949, to Jan 14, 1951, that I last saw the deceased alive on Jan 14, 1951, and that death occurred at 4:48 A. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

| | | | | |
|---|--------------------------|-------------------------------------|----------------------------------|-----------|
| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State) |
| <u>Burial</u> | <u>1/16/51</u> | <u>Wicomico Cemetery, Salisbury</u> | <u>Salisbury</u> | <u>MD</u> |
| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS | |
| <u>1-15-51</u> | <u>Marjorie Holloway</u> | <u>Chas. H. Holloway</u> | <u>Salisbury, Md.</u> | |

950 506



(Dr. Wm Smith)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 336

0962

| | | | |
|---|-------------------------------|--|--|
| 1. PLACE OF DEATH: COUNTY <u>McComick</u> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MD.</u> COUNTY <u>McComick</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Deemas</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Powellville</u> | |
| TOWN <u>Deemas</u> | | TOWN <u>Powellville</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Friendly Nursing Home</u> | | STREET ADDRESS (If rural give location) <u>in village</u> | |
| 3. NAME OF DECEASED (First) <u>Mary</u> (Middle) <u>Myrtle</u> (Last) <u>Adkins</u> | | 4. DATE OF DEATH (Month) <u>Jan</u> (Day) <u>22</u> (Year) <u>1951</u> | |
| 5. SEX <u>female</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE OR MARRIED, WIDOWED, DIVORCED, (Specify) <u>at home</u> | 8. DATE OF BIRTH <u>May 4-1897</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house work</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u> | 9. AGE last birthday <u>53</u> yrs. If under 1 year Months Days Hours Min. |
| 11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>John Hardy Adkins</u> | | 14. MOTHER'S MAIDEN NAME <u>Abelia A. Bailey</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>907 Beechfield Ave. Annapolis</u> | |
| 17. INFORMANT <u>M. Glanville F. Adkins (Brother)</u> | | 18. MEDICAL CERTIFICATION <u>29-2-51</u> | |

| | | | |
|---|--|---|--|
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | 18. MEDICAL CERTIFICATION | |
| 260x Immediate cause (a) <u>Cardiac Decompensation</u> | | 29-2-51 | |
| 61 Antecedent cause(s) (b) <u>Diabetes</u> | | | |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Nephritis</u> | | | |
| II. OTHER SIGNIFICANT CONDITIONS | | | |
| Conditions contributing to the death but not related to the disease or condition causing death. | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/> | | | |
| 21. ACCIDENT (Specify) SUICIDE HOMICIDE | | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> | |
| HOW DID INJURY OCCUR? | | | |

22. I hereby certify that I attended the deceased from 1-20, 1951, to 1-23, 1951, that I last saw the deceased

alive on 1-20, 1951, and that death occurred at 12:35 P., from the causes and on the date stated above.

SIGNATURE (Degree or title) Wm B. Smith M.D. ADDRESS Salisbury, Md DATE SIGNED 1-23-51

| | | | |
|---|------------------------|---|---|
| 23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u> | DATE <u>Jan. 24-51</u> | NAME OF CEMETERY OR CREMATORY <u>McComick Mem. Park</u> | LOCATION (city, town, or county) <u>Salisbury Md.</u> (State) |
|---|------------------------|---|---|

DATE REC'D BY LOCAL REG. January 23-1951 REGISTRAR'S SIGNATURE Harry E. Anderson 24. FUNERAL DIRECTOR Hollman & Co. Salisbury Md. ADDRESS Dallas R. Hollman

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Evidence for addition

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

0964

in #18 shown on:

FILM No. G 130 JAN 17 1951

CERTIFICATE OF DEATH

Reg. Dist. No. 332

| | | | | | |
|---|------------------------------|---|---|--|--|
| 1. PLACE OF DEATH: COUNTY <u>Wicomico</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> TOWN <u>Salisbury</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u> | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Wicomico</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> TOWN <u>Salisbury</u> RURAL # <u>2</u> STREET ADDRESS (If rural, give location) <u>Salisbury</u> | | |
| 3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Ray</u> <u>Agnes</u> | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>Jan</u> <u>6</u> <u>1951</u> | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>C</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>Aug 14 - 1936</u> | 9. AGE last birthday <u>14</u> yrs. | If under 1 year Months Days Hours Mins. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>School</u> | 11. BIRTHPLACE (State or foreign country) <u>Salisbury, Md</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13. FATHER'S NAME <u>John Agnes</u> | | | 14. MOTHER'S MAIDEN NAME <u>Annie Harmon</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY No. <u>none</u> | 17. INFORMANT AND ADDRESS <u>John Agnes Salisbury, Md Peninsula</u> | | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Rheumatic Heart Disease

INTERVAL BETWEEN ONSET AND DEATH

6 weeks

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

Rheumatic Fever - active at time of death.
(1-17-51 - ams)

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

| | | | | |
|--|---|-----------------------|----------|---------|
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE) |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> | HOW DID INJURY OCCUR? | | |

22. I hereby certify that I attended the deceased from 12/15, 1950, to 1-6, 1951, that I last saw the deceasedalive on 1/6, 1951, and that death occurred at 8:38 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

| | | | | |
|--|--------------------------|----------------------------------|----------------------------------|-----------|
| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State) |
| <u>Burial</u> | <u>Jan 9/51</u> | <u>Layton Park</u> | <u>Salisbury</u> | <u>Md</u> |
| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR ADDRESS | | |
| <u>1-6-51</u> | <u>Mary W. Hollenray</u> | <u>May O'Brien Salisbury, Md</u> | | |

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

WASHINGTON, D. C.



MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change

Dr. *Brumley*

of age shown on:

FILM No. G 130 JAN 16 1951

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

6965

CERTIFICATE OF DEATH

Reg. Dist. No. *532*

| | | | |
|--|--------------------------------------|--|---|
| 1. PLACE OF DEATH- COUNTY <i>Wicomico</i> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <i>Maryland</i> COUNTY <i>Wicomico</i> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i> | | CITY (If outside corporate limits, write RURAL and give nearest town) <i>Fruitland</i> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Pen. Gen. Hospital</i> | | STREET ADDRESS <i>R. D. # I</i> (If rural, give location) | |
| 3. NAME OF DECEASED (Type or Print) <i>Albertie</i> | (First) (Middle) (Last) <i>Banks</i> | 4. DATE OF DEATH <i>Jan. 4 1951</i> | (Month) (Day) (Year) |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i> | 8. DATE OF BIRTH <i>June 6-1882</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Work</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i> | 11. BIRTHPLACE (State or foreign country) <i>Near Allen Md.</i> |
| 13. FATHER'S NAME <i>Albert Brumley</i> | | 14. MOTHER'S MAIDEN NAME <i>Emily Chatham</i> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service) | | 17. INFORMANT AND ADDRESS <i>Mr. Albert T. Banks</i> | |

18. MEDICAL CERTIFICATION *Fruitland Md.*

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) *Cerebral Thrombosis*

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) *Central Arteriosclerosis*(c) *Diabetes Mellitus*

INTERVAL BETWEEN ONSET AND DEATH

9 days
*2 yrs*II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

| | | | | |
|--|---|-----------------------|----------|---------|
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) <i>INJURY</i> | (CITY OR TOWN) | (COUNTY) | (STATE) |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> | HOW DID INJURY OCCUR? | | |

22. I hereby certify that I attended the deceased from *Dec. 26*, 19*50*, to *Jan. 4*, 19*51*, that I last saw the deceasedalive on *Jan. 4*, 19*51*, and that death occurred at *4:25* A. M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

| | | | | |
|--|---|---|--|---------|
| 23. BURIAL CREMATION REMOVAL (Specify) <i>Burial</i> | DATE THEREOF <i>Jan. 7-1951</i> | NAME OF CEMETERY OR CREMATORY <i>Banks Family Cemetery</i> | LOCATION (City, town, or county) <i>Near Fruitland Md.</i> | (State) |
| DATE REC'D BY LOCAL REG. <i>1-6-51</i> | REGISTRAR'S SIGNATURE <i>Mary W. Holloway</i> | 24. FUNERAL DIRECTOR ADDRESS <i>Holloway & Company - Salisbury, Md.</i> | | |

Walter R. Holloway



PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition
of 8 & 9 shown on:

FILE No. G 130 JAN 31 1951

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH FOR MEDICAL EXAMINERS

Reg. Dist. No. 332

| | | | |
|---|--------------------------------|--|--|
| 1. PLACE OF DEATH COUNTY <u>Salisbury</u> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>Salisbury</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury MD</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>none</u> | | STREET ADDRESS (if rural give location) <u>none</u> | |
| 3. NAME OF DECEASED (Type or Print) <u>Sam</u> | | 4. DATE OF DEATH (Month) <u>1</u> (Day) <u>14</u> (Year) <u>1951</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>Cal</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>none</u> | 8. DATE OF BIRTH <u>August 1913</u> |
| 9. AGE last birthday <u>37 yrs.</u> | | 10. If under 1 year Months Days Hours Mln. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mill hand</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>none</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>none</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>none</u> | |
| 13. FATHER'S NAME <u>none</u> | | 14. MOTHER'S MAIDEN NAME <u>none</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY No. | |
| 17. INFORMANT | | | |
| 18. MEDICAL CERTIFICATION | | | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | INTERVAL BETWEEN ONSET AND DEATH |
| (a) Immediate cause <u>983x</u> <u>Lacerated Brain</u> | | | <u>instant</u> |
| (b) Antecedent cause(s) <u>168</u> <u>Fractured skull</u> | | | <u>instant</u> |
| (c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>none</u> | | | |
| 19a. DATE OF OPERATION <u>none</u> | | 19b. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | |
| 21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> | | PLACE (Home, farm, factory, street, office bldg, etc.) INJURY <u>working lat</u> | |
| (CITY OR TOWN) <u>Salisbury</u> (COUNTY) <u>Worcester</u> (STATE) <u>MD</u> | | | |
| TIME (Month) (Day) (Year) (Hour) OF INJURY <u>1</u> <u>14</u> <u>51</u> <u>12</u> m. | | INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| HOW DID INJURY OCCUR? <u>struck on head by 2 x 4</u> | | | |
| 22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input checked="" type="checkbox"/> , undetermined <input type="checkbox"/> . | | | |
| SIGNATURE <u>for Rademacher MD</u> | | DATE SIGNED <u>Salisbury MD 1/14/51</u> | |
| 23. BURIAL CREMATION REMOVAL (Specify) <u>1-24-51</u> | | NAME OF CEMETERY OR CREMATORY <u>Public</u> | |
| LOCATION (City, town, or county) <u>Salisbury</u> (State) <u>MD</u> | | | |
| DATE REC'D BY LOCAL REG. <u>1 23 51</u> | | 24. FUNERAL DIRECTOR <u>Zooker M. Tacey</u> <u>Salisbury MD. 690VVV</u> | |



MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

0967

Reg. Dist. No. 335

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH- COUNTRY <u>Wicomico</u> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Wicomico</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Sharptown</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Sharptown</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>School St.</u> | | STREET ADDRESS (If rural give location) <u>School St.</u> | |
| 3. NAME OF DECEASED (Type or Print) | (First) <u>CHARLOTTE</u> | (Middle) <u>ELIZABETH</u> | (Last) <u>BRADLEY</u> |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>July 24, 1869</u> |
| 9. AGE last birthday <u>81</u> yrs. | | 4. DATE OF DEATH (Month) <u>Jan.</u> (Day) <u>11</u> (Year) <u>51</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Alfred Twiford</u> | | 14. MOTHER'S MAIDEN NAME <u>Charlotte Wheaterly</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT <u>Mrs. Paul Ellis</u> | | | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

422.1 Immediate cause (a) Acute congestive heart failure

93d Antecedent cause(s) (b) Arterio-sclerotic cardio-vascular disease

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

| | | |
|--|---|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | PLACE (Home, farm, factory, street, or office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE) |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | HOW DID INJURY OCCUR? |

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☐ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

| | | | | |
|---|--|--|----------------------------------|------------|
| 23. BURIAL, CREMATION REMAINS (Specify) | DATE TIME OF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State) |
| <u>Burial</u> | <u>1-16-51</u> | <u>Firemans</u> | <u>Sharptown</u> | <u>Md.</u> |
| DATE REC'D BY LOCAL REG. <u>1/16/51</u> | REGISTRAR'S SIGNATURE <u>Walter B. Mann</u> | 24. FUNERAL DIRECTOR <u>Paul J. Smith</u> | <u>Sharptown, Md.</u> | |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

18. 1948



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

| | | | |
|--|---------------------------------|--|------------------------------------|
| 1. PLACE OF DEATH- COUNTRY <u>WISCONSIN</u> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Worcester</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Peninsula General Hospital</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u> | | STREET ADDRESS (If rural, give location) <u>Branch Street</u> | |
| 3. NAME OF DECEASED (Type or Print) <u>Shumway</u> | (First) (Middle) (Last) | 4. DATE OF DEATH <u>January 27</u> | (Month) (Day) (Year) |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>Colored</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH <u>12-19-44</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School child</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE last birthday <u>6 yrs.</u> |
| 11. BIRTHPLACE (State or foreign country) <u>Peninsula Gen. Hospital Salisbury, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <u>Shumway, F. Brittingham</u> | | 14. MOTHER'S MAIDEN NAME <u>Evelyn Taylor</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY No. <u>None</u> | |
| 17. INFORMANT AND ADDRESS <u>Shumway F. Brittingham, Berlin, Md.</u> | | 18. MEDICAL CERTIFICATION | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 4652 Immediate cause (a) <u>Sub-acute myocarditis with congestive failure, etiology undetermined</u> | | 2 mo. | |
| 93a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Sub-acute pericarditis</u> | | unknown | |
| (c) <u>Pulmonary infarct, right middle lobe</u> | | unknown | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | (STATE) | |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | | PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) | |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | | INJURY OCCURRED While at Not While at Work <input type="checkbox"/> At work <input type="checkbox"/> | |
| HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>16 Jan., 1957</u> , to <u>27 Jan., 1957</u> , that I last saw the deceased alive on <u>27 Jan., 1957</u> , and that death occurred at <u>9:50 P.M.</u> , from the causes and on the date stated above. | | | |
| SIGNATURE <u>Albert W. Kline, M.D.</u> | | ADDRESS <u>Salisbury, Md.</u> DATE SIGNED <u>28 Jan. 1957</u> | |
| 23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u> | | DATE THEREOF <u>1-31-57</u> | |
| NAME OF CEMETERY OR CREMATORY <u>Evergreen Cemetery</u> | | LOCATION (City, town, or county) (State) <u>Berlin, Worcester Co. Md.</u> | |
| DATE REC'D BY LOCAL REG. <u>1-30-57</u> | | REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u> | |
| FUNERAL DIRECTOR <u>James B. Daskill</u> | | ADDRESS <u>Salisbury, Md.</u> | |

RECEIVED
FEB 2 1951
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

| | | | |
|---|--|--|---------------------------------------|
| 1. PLACE OF DEATH COUNTY <u>Wicomico</u> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Wicomico</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hosp. Inc.</u> | | STREET ADDRESS (If rural, give location) <u>Route 4</u> | |
| 3. NAME OF DECEASED (Type or Print) | (First) <u>Joseph</u> (Middle) <u>William</u> (Last) <u>Cannon</u> | 4. DATE OF DEATH (Month) (Day) (Year) <u>January 22 1951</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH <u>May 30 - 1864</u> |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 11. BIRTH PLACE (State or foreign country) | |
| <u>Retired Farmer</u> | | <u>Wicomico Co. Md.</u> | |
| 13. FATHER'S NAME <u>William Cannon</u> | | 14. MOTHER'S MARRIED NAME <u>Sarah Cannon</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 17. INFORMANT AND ADDRESS <u>M. Joseph W. Cannon (son)</u> | |
| 16. SOCIAL SECURITY No. | | 12. CITIZEN OF WHAT COUNTRY? | |
| | | <u>U.S.A.</u> | |

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1 Immediate cause

(a)

Cardiac Decompensation

Antecedent cause(s)

93d

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Chronic C-V Disease

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

| | | | | |
|----------------------------------|---|-----------------------|----------|---------|
| 21. ACCIDENT (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE) |
| SUICIDE HOMICIDE | INJURY | | | |
| TIME (Month) (Day) (Year) (Hour) | INJURY OCCURRED | HOW DID INJURY OCCUR? | | |
| OF INJURY | While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> | | | |

22. I hereby certify that I attended the deceased from Apr, 1950, to Jan 22, 1951, that I last saw the deceased alive on Jan 22, 1951, and that death occurred at 9:50 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

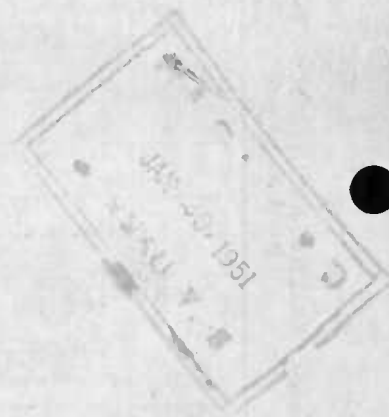
DATE SIGNED

| | | | | |
|---|-------------------------|---------------------------------|----------------------------------|---------|
| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State) |
| | <u>Jan. 25-51</u> | <u>Parson's Cem.</u> | <u>Salisbury Md.</u> | |
| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS | |
| <u>1-24-51</u> | <u>Mary W. Holloway</u> | <u>William R. Holloway Inc.</u> | <u>100105</u> | |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



Dr. Bramme

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH COUNTY <u>McCombs</u> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Ind.</u> COUNTY <u>McCombs</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Lafayette</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Lafayette</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1108 East Isabelle St.</u> | | STREET ADDRESS (If rural, give location) <u>112 East Isabelle St.</u> | |
| 3. NAME OF DECEASED (Type or Print) <u>Mary</u> (First) <u>Adaline</u> (Middle) <u>Chambelin</u> (Last) | | 4. DATE OF DEATH Jan 31 - 51 | |
| 5. SEX <u>female</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH <u>April 23 - 1875</u> - 75 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home mkr</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u> | 9. AGE last birthday If under 1 year If under 24 hrs. Months Days Hours Min. |
| 11. FATHER'S NAME <u>Samuel Holland</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13. MOTHER'S NAME <u>Anna Bell Converse</u> | | 14. MOTHER'S MAIDEN NAME | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If year, give war or dates of service) <u>No.</u> | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Miss Adabelle Chambelin</u> | | | |

| | | |
|---|---|--|
| 18. MEDICAL CERTIFICATION <u>112 E. Isabelle St. Lafayette Ind.</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u> |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | |
| Immediate cause (a) <u>Cerebral Hemorrhage</u> | | |
| Antecedent cause(s) (b) <u>Arterio-sclerosis - hypertensive</u> | | |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | |
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 21. ACCIDENT (Specify) SUICIDE HOMICIDE | PLACE (Home, farm, factory, street, office bldg., etc.) INJURY | (CITY OR TOWN) (COUNTY) (STATE) |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> | HOW DID INJURY OCCUR? |

22. I hereby certify that I attended the deceased from 1949, 19....., to Jan 31, 1951, that I last saw the deceased alive on Jan 31, 1951, and that death occurred at 6:50 P m. from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

| | | | |
|---|--|---|---|
| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE <u>Feb. 3-51</u> | NAME OF CEMETERY OR CREMATORY <u>Purtyman Cem.</u> | LOCATION (City, town, or county) (State) <u>Union Anne Md.</u> |
| DATE REC'D BY LOCAL REG. <u>2-1-51</u> | REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u> | 24. FUNERAL DIRECTOR <u>Hollman & Co. Lafayette Ind.</u> | ADDRESS <u>Walter R. Hollman</u> |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

| | | | |
|--|-------------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH COUNTY <u>McCombs</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> TOWN <u>Salisbury</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>114. Bay St.</u> | | 2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>McCombs</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> TOWN <u>Salisbury</u> STREET ADDRESS (If rural, give location) <u>114. Bay St.</u> | |
| 3. NAME OF DECEASED (Type or Print) <u>Margaret</u> (First) <u>Cooper</u> (Middle) <u>Cooper</u> (Last) | | 4. DATE OF DEATH (Month) <u>Jan.</u> (Day) <u>16</u> (Year) <u>1951</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>June 8-1873</u> |
| 9. AGE last birthday <u>77</u> yrs. | | 10. AGE last birthday If under 1 year If under 24 hrs. Months Days Hours Min. | |
| 11a. USUAL OCCUPATION (Give kind of work done during most of preceding life, if not retired) <u>Housewife</u> | | 11b. KIND OF BUSINESS OR INDUSTRY <u>at home</u> | |
| 12. BIRTHPLACE (State or foreign country) <u>Scotland</u> | | 13. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 14. FATHER'S NAME <u>John Marshall</u> | | 15. MOTHER'S MAIDEN NAME <u>Jessie Allen</u> | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 17. SOCIAL SECURITY No. <u>114. Bay St. Salisbury Md.</u> | |
| 18. INFORMANT AND ADDRESS <u>Mr. William Perkins (daughter)</u> | | | |

| | | | | | |
|--|--|---|--|---|--|
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | 18. MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH | |
| Immediate cause (a) <u>Constrictive Heart Failure</u> | | | | <u>2 weeks</u> | |
| Antecedent cause(s) (b) <u>Diabetic Gangrene</u> | | | | <u>6 months</u> | |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Arteriosclerotic Heart Disease</u> | | | | <u>(?)</u> | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Diabetes Mellitus</u> | | | | <u>10 years</u> | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 21. ACCIDENT (Specify) <u>HOMICIDE</u> | | PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u> | | (CITY OR TOWN) (COUNTY) (STATE) | |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> | | HOW DID INJURY OCCUR? | |

22. I hereby certify that I attended the deceased from Aug 20, 1949, to Jan 16, 1951, that I last saw the deceased alive on Jan 16, 1951, and that death occurred at 12.15 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) John H. Yeman M.D. ADDRESS 238 Canider Ave Salisbury Md. DATE SIGNED 1/16/51

| | | | | |
|---|-----------------------|-------------------------------|----------------------------------|---------|
| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State) |
| <u>Jan - 20-51</u> | <u>Northwood Cem.</u> | <u>Plata.</u> | <u>Pa.</u> | |

| | | | |
|---|---|---|--------------------------------|
| DATE REC'D BY LOCAL REG. <u>1-16-51</u> | REGISTRAR'S SIGNATURE <u>Mary W. Hollonay</u> | 24. FUNERAL DIRECTOR <u>Will Mayole Salisbury Md.</u> | ADDRESS <u>Will R Hollonay</u> |
|---|---|---|--------------------------------|

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

| | | | |
|--|-------------------------------|---|---|
| 1. PLACE OF DEATH COUNTY <u>Wicomico</u> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Sussex</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Blades</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Charmula Ben. Hosp.</u> | | STREET ADDRESS <u>300 J. Market St.</u> (If rural, give location) | |
| 3. NAME OF DECEASED (Type or Print) <u>Ralph</u> (First) <u>Ray</u> (Middle) <u>Coulbourne</u> (Last) | | 4. DATE OF DEATH (Month) <u>1</u> (Day) <u>9</u> (Year) <u>1951</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH <u>Jan. 14, 1880</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Broker</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Produce</u> | 9. AGE last birthday <u>70</u> yrs. <u>11</u> Months <u>9</u> Days <u>19</u> Hours <u>15</u> Min. |
| 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Wm. Coulbourne</u> | | 14. MOTHER'S MAIDEN NAME <u>Rosa Richardson</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY No. | |
| 17. INFORMANT AND ADDRESS <u>Mrs. Shelma C. Passwaters</u> | | | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Arterio-sclerotic Heart Disease & Hypertension

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) _____

(c) _____

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.)

TIME (Month) (Day) (Year) (Hour) OF INJURY m. INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/19, 1950, to 1/8, 1951, that I last saw the deceased

alive on 1/5, 1951, and that death occurred at 12:25 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF 1/11/51

NAME OF CEMETERY OR CREMATORY Salisbury, Md.

LOCATION (City, town, or county) Salisbury, Md.

(State)

DATE REC'D BY LOCAL REG. 1-11-51

REGISTRAR'S SIGNATURE Mary W. Holloman

24. FUNERAL DIRECTOR

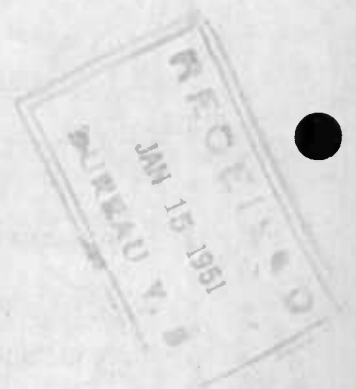
ADDRESS The New Johnson Co.

George H. Hise 290609

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition
in #18 shown on;

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

0973

FILE No. G 131 MAR 20 1951 CERTIFICATE OF DEATH

Reg. Dist. No. 332

| | | | |
|--|-------------------------------|---|---|
| 1. PLACE OF DEATH COUNTY <u>Wicomico</u> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Wicomico</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>RLD.</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u> | | STREET ADDRESS (If rural, give location) <u>✓</u> | |
| 3. NAME OF DECEASED (Type or Print) (First) <u>Kennard</u> (Middle) <u>John</u> (Last) <u>Dennis</u> | | 4. DATE OF DEATH (Month) <u>January</u> (Day) <u>12</u> (Year) <u>1951</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>Aug 5, 1919</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>working life</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | 9. AGE last birthday <u>1</u> yrs. <u>5</u> months <u>7</u> days <u>7</u> hours <u>—</u> min. |
| 11. BIRTHPLACE (State or foreign country) <u>Berlin Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Lloyd W. Dennis</u> | | 14. MOTHER'S MAIDEN NAME <u>Reba Butteringham</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY No. <u>—</u> | |
| 17. INFORMANT AND ADDRESS <u>Mrs. Lloyd Dennis Berlin Md.</u> | | | |
| 18. MEDICAL CERTIFICATION | | | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | INTERVAL BETWEEN ONSET AND DEATH |
| Immediate cause (a) <u>acute meningitis, organism undetermined</u> Antecedent cause(s) (b) <u>(3/19/51 aka)</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>—</u> | | | <u>7 10 hrs.</u> |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/> | | | |
| 21. ACCIDENT (Specify) <u>SUICIDE</u> | | PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u> | |
| TIME (Month) (Day) (Year) (Hour) <u>—</u> | | HOW DID INJURY OCCUR? <u>While at Work</u> <input type="checkbox"/> <u>Not While at work</u> <input type="checkbox"/> | |
| 22. I hereby certify that I attended the deceased from <u>1/12</u> , 19 <u>51</u> , to <u>1/12</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>1/12</u> , 19 <u>51</u> , and that death occurred at <u>5:20 A.M.</u> , from the causes and on the date stated above. | | | |
| SIGNATURE <u>J. Earl Furman M.D.</u> | | ADDRESS <u>Peninsula General Hosp.</u> DATE SIGNED <u>1/12/51</u> | |
| 23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u> | | DATE THEREOF <u>1/15/51</u> | |
| NAME OF CEMETERY OR CREMATORY <u>Evergreen</u> | | LOCATION (City, town, or county) (State) <u>Berlin Md</u> | |
| DATE REC'D BY LOCAL REG. <u>1-15-51</u> | | REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u> | |
| FUNERAL DIRECTOR <u>Anna A. Burhop</u> | | ADDRESS <u>Berlin Md</u> | |



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

The correct age
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

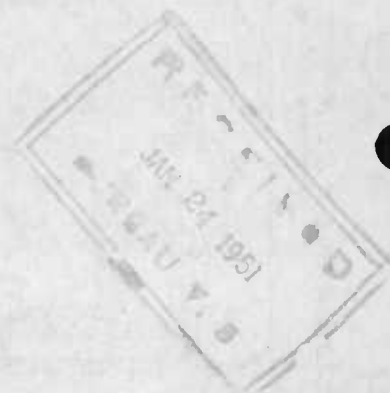
MARGIN RESERVED FOR BINDING

| | | | |
|--|-------------------------------|--|---|
| 1. PLACE OF DEATH- COUNTY <u>Wicomico</u> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Somerset</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u> | | STREET ADDRESS (If rural, give location) <u>R.F.D.</u> | |
| 3. NAME OF DECEASED (Type or Print) (First) <u>Sadie</u> (Middle) <u>Dryden</u> (Last) <u>Dryden</u> | | 4. DATE OF DEATH (Month) <u>Jan.</u> (Day) <u>19</u> (Year) <u>1950</u> | |
| 5. SEX <u>female</u> | 6. COLOR OR RACE <u>white</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u> | 8. DATE OF BIRTH <u>Sept. 6, 1883</u> 67 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>home</u> | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> |
| 13. FATHER'S NAME <u>Rufus Dryden</u> | | 14. MOTHER'S MAIDEN NAME <u>Ida Long Dryden</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>no</u> | | 17. INFORMANT AND ADDRESS <u>Mr. Bernard C. Dryden Pr. Anne, Md.</u> | |

| | | |
|---|---|--|
| 18. MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | |
| (a) Immediate cause <u>Arteriosclerotic renal disease</u> | | <u>5 days</u> |
| (b) Antecedent cause(s) <u>Cystocele, marked</u> | | <u>30 yrs</u> |
| (c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | |
| 19a. DATE OF OPERATION <u>1-10-51</u> | | 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 19b. MAJOR FINDINGS OF OPERATION <u>Cystocele + rectocele</u> | | |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF industry bldg., etc.) INJURY | (CITY OR TOWN) (COUNTY) (STATE) |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> | HOW DID INJURY OCCUR? |

22. I hereby certify that I attended the deceased from 1-7, 1951, to 1-19, 1951, that I last saw the deceased alive on 1-18, 1951, and that death occurred at 11:00 A.M., from the causes and on the date stated above.

| | |
|--|--|
| SIGNATURE <u>H. B. Hall</u> | DATE SIGNED <u>1-20-51</u> |
| 23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u> | DATE THEREOF <u>1-21-1951</u> |
| NAME OF CEMETERY OR CREMATORY <u>St. Andrew Cemetery</u> | LOCATION (City, town, or county) <u>Princess Anne, Md.</u> |
| DATE REC'D BY LOCAL REG. <u>1-20-51</u> | REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u> |
| 24. FUNERAL DIRECTOR <u>Lester R. Wilson</u> ADDRESS <u>Princess Anne, Md.</u> | |



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH; COUNTY <u>Wicomico</u> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED; STATE <u>Maryland</u> COUNTY <u>Wicomico</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Camden & Pennsylvania Ave.</u> | | STREET ADDRESS (If rural, give location) <u>Camden & Pennsylvania Ave.</u> | |
| 3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>SAMUEL S FELDMAN</u> | | 4. DATE OF DEATH (Month) (Day) (Year) <u>1 - 20 1957</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>June 29, 1983</u> |
| 9. AGE last birthday <u>68</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hardware retailer</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Pottstown, Pa.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Isaac Feldman</u> | | 14. MOTHER'S MAIDEN NAME <u>Esther Furkash</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>none</u> | | 16. SOCIAL SECURITY NO. <u>none</u> | |
| 17. INFORMANT AND ADDRESS <u>Harry Miller, Virginia Ave. Salisbury</u> | | | |

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Pulmonary Embolism

Antecedent cause(s) (b)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

| | | | | |
|--|---|-----------------------|----------|---------|
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> | HOW DID INJURY OCCUR? | | |

22. I hereby certify that I attended the deceased from 1-19, 1957, to 1-29, 1957, that I last saw the deceasedalive on 1-19, 1957, and that death occurred at 1:40 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

| | | | | |
|---|-------------------------|------------------------------------|----------------------------------|------------|
| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State) |
| | <u>1-21-57</u> | <u>Becker, Cholan Cemetery</u> | <u>Philadelphia</u> | <u>Pa.</u> |
| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS | |
| <u>1-20-57</u> | <u>Mary W. Holloway</u> | <u>The Kelly & Johnson Co.</u> | <u>Salisbury Md</u> | |
| | | <u>George C. Kelly</u> | <u>290658</u> | |

MARGIN RESERVED FOR BINDING

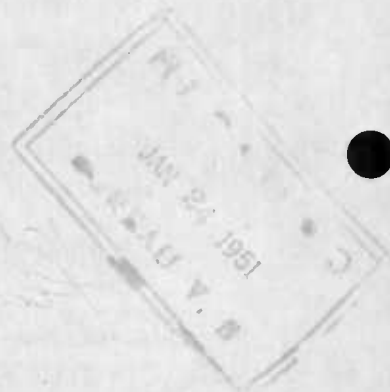
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

University of California

PA-1

PA-1



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

| | | | |
|---|----------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH COUNTY <u>Wicomico</u> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>Worcester</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Newark</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Roundbush General Hospital</u> | | STREET ADDRESS (If rural, give location) <u>Newark</u> | |
| 3. NAME OF DECEASED (Type or Print) | (First) <u>John</u> | (Middle) <u>D</u> | (Last) <u>Tindley</u> |
| 4. DATE OF DEATH | (Month) <u>1</u> | (Day) <u>9</u> | (Year) <u>1951</u> |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>C.</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u> | 8. DATE OF BIRTH <u>11-9-33</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | 9. AGE last birthday <u>17</u> yrs. |
| 11. BIRTH PLACE (State or foreign country) <u>Newark - Worcester Md</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>George Tindley</u> | | 14. MOTHER'S MAIDEN NAME <u>Father Marshall</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY No. <u>None</u> | |
| 17. INFORMANT AND ADDRESS <u>Hester Tindley, Newark Md Rte 1</u> | | | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

9160 Immediate cause (a) Burne nearly whole bodyAntecedent cause(s) (b) including dead septemitiesDiseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Decedent was mentally deficient and left in home alone day he was burned and his clothing caught fire.II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN ONSET AND DEATH
10 hours

20. AUTOPSY?

Yes ☐ No ☒21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) Home(CITY OR TOWN) Newark(COUNTY) Worcester(STATE) MdTIME (Month) (Day) (Year) (Hour) OF INJURY 1 9 1951 11:30 m.INJURY OCCURRED While at Work ☐ Not While at Work ☒HOW DID INJURY OCCUR? Caught fire from bed he had set afire22. I hereby certify that I attended the deceased from 9:15 P, 1951, to 11:30 P, 1951, that I last saw the deceasedalive on 11:30 P, 1951, and that death occurred at 11:30 P m., from the causes and on the date stated above.

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) BurialDATE THEREOF 1-12-51NAME OF CEMETERY OR CREMATORY Evergreen CemeteryLOCATION (City, town, or county) Berlin, Worcester Co.(State) MdDATE REC'D BY LOCAL REG. 1-15-51REGISTRAR'S SIGNATURE Mary W. Holloway24. FUNERAL DIRECTOR James B. DashiellADDRESS Salisbury Md.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH COUNTY <u>Wicomico</u> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Wicomico</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u> | | STREET ADDRESS (If rural, give location) <u>Route 3</u> | |
| 3. NAME OF DECEASED (Type or Print) | (First) <u>Hunter</u> (Middle) <u>Mann</u> (Last) <u>Fitzgerald</u> | 4. DATE OF DEATH | (Month) <u>January</u> (Day) <u>14</u> (Year) <u>1951</u> |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH <u>January 2, 1951</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE last birthday | If under 1 year Months <u>14</u> Days <u>14</u> Hours <u>14</u> Min. <u>14</u> |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Roland Fitzgerald</u> | | 14. MOTHER'S MAIDEN NAME <u>Ethel Fitzgerald</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY No. | |
| 17. INFORMANT AND ADDRESS <u>Roland Fitzgerald</u> | | | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

762.5 Immediate cause (a) Respiratory failure
 Antecedent cause(s) (b) Prematurity
 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

INTERVAL BETWEEN ONSET AND DEATH

24 hrs

14 days

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐ (STATE)

21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY)

HOMICIDE INJURY

TIME (Month) (Day) (Year) (Hour) INJURY OCCURRED HOW DID INJURY OCCUR?
 OF While at Not While
 INJURY m. Work ☐ At work ☐

22. I hereby certify that I attended the deceased from Jan 2, 1951, to Jan 14, 1951, that I last saw the deceased alive on Jan 14, 1951, and that death occurred at 3:40 A. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

William C. Morgan

M.D.

Salisbury, Md.

Jan. 14, 1951

23. BURIAL, CREMATION REMOVAL (Specify) DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)

1/15/51 Peninsula General Hospital Salisbury Md

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

1-15-51

Mary W. Holloway

Peninsula General Hospital

Salisbury, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

OFFICE OF THE SECRETARY OF DEFENSE

WASHINGTON, D. C. 20301

MEMORANDUM FOR THE SECRETARY

SUBJECT:

1. The following information was received from the

2. The information was received from the

3. The information was received from the

4. The information was received from the

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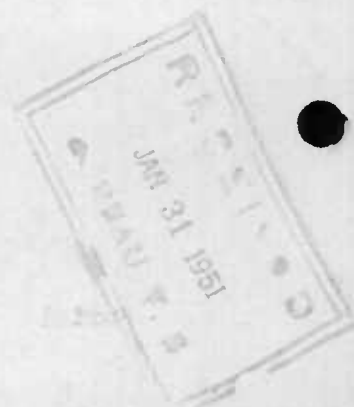
MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

Reg. Dist. No. 332

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH- COUNTY <u>Wicomico</u> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Wicomico</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Mardela</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>P. G. Hospt.</u> | | STREET ADDRESS (If rural give location) | |
| 3. NAME OF DECEASED (Type or Print) <u>Wm. Truitt</u> | (First) (Middle) (Last) | 4. DATE OF DEATH (Month) (Day) (Year) <u>1</u> <u>26</u> <u>1951</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>Oct. 2, 1888</u> |
| 9. AGE last birthday <u>62</u> yrs. | | 10. If under 1 year: Months <u>1</u> Days <u>26</u> Hours <u>19</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during last working life, even if retired) <u>Carpenter</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Bulker</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Mardela Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <u>Samuel Gillis</u> | | 14. MOTHER'S MAIDEN NAME <u>Elizabeth Brown</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Mr. Wilson T. Gillis (Son)</u> | | 18. MEDICAL CERTIFICATION <u>Spring Hill Road, Salisbury, Md.</u> | |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>Immediate cause</u> <u>Coronary Occlusion</u> <u>Antecedent cause(s)</u> <u>420.1 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u> <u>94a</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | |
| 21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | | INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| | | HOW DID INJURY OCCUR? | |
| 22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> . | | | |
| SIGNATURE <u>Earl H. Royer, M.D.</u> | | DATE SIGNED <u>1/26/51</u> | |
| 23. BURIAL, CREMATION OR OTHER (Specify) <u>Burial</u> | | DATE THEREOF <u>Jan 29, 51.</u> | |
| NAME OF CEMETERY OR CREMATORY <u>Mardela Cem.</u> | | LOCATION (City, town, or county) (State) <u>Mardela, Md.</u> | |
| DATE REC'D BY LOCAL REG. <u>1-29-51</u> | | REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u> | |
| 24. FUNERAL DIRECTOR <u>Holloway & Co.</u> | | ADDRESS <u>Salisbury, Md.</u> | |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

| | | | |
|--|---|--|---------------------------------------|
| 1. PLACE OF DEATH COUNTY <i>Wicomico</i> MARYLAND | | 2. USUAL RESIDENCE (HOME), OF DECEASED STATE <i>Maryland</i> COUNTY <i>Sorchester</i> | |
| CITY (If outside corporate limits, write RURAL and OR give nearest town) <i>Salisbury</i> LENGTH OF STAY (in this place) <i>2 yrs 5 mo</i> | | CITY (If outside corporate limits, write RURAL and give nearest town) <i>Brookview</i> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Deer's Head State Hosp</i> | | STREET ADDRESS (If rural, give location) <i>✓</i> | |
| 3. NAME OF DECEASED (Type or Print) | (First) <i>Otha</i> (Middle) <i>Griffith</i> (Last) <i>Griffith</i> | 4. DATE OF DEATH (Month) (Day) (Year) <i>Jan. 16 1951</i> | |
| 5. SEX <i>m</i> | 6. COLOR OR RACE <i>w</i> | 7. SINGLE MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i> | 8. DATE OF BIRTH <i>Feb. 27, 1874</i> |
| 9. AGE last birthday <i>76</i> yrs. | | 10. AGE last birthday (If under 1 year) (Months) (Days) (Hours) (Min.) | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>None</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>John Griffith</i> | | 14. MOTHER'S MAIDEN NAME <i>Harriett E. Andrew</i> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>Unknown</i> | | 16. SOCIAL SECURITY No. <i>None</i> | |
| 17. INFORMANT AND ADDRESS <i>Hospital Record</i> | | | |

| | | | |
|---|---|---|------------------|
| 18. MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH | |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | |
| 4301 Immediate cause (a) <i>Myocardial infarction</i> | | <i>~ 1.5 yrs</i> | |
| 94a Antecedent cause(s) (b) <i>Coronary insufficiency</i> | | <i>~ 1.5 yrs</i> | |
| (c) <i>Arteriosclerosis, General</i> | | <i>~ 2 yrs</i> | |
| 11. OTHER SIGNIFICANT CONDITIONS (Conditions contributing to the death but not related to the disease or condition causing death.) <i>a) Anemia secondary b) Pariah neoplasm of the lung?</i> | | <i>~ 1 year ~ 1 year</i> | |
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 21. ACCIDENT (Specify) <i>SUICIDE HOMICIDE</i> | PLACE (Home, farm, factory, street, OF office bldg., etc.) <i>INJURY</i> | (CITY OR TOWN) | (COUNTY) (STATE) |
| TIME (Month) (Day) (Year) (Hour) OF INJURY <i>m.</i> | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> | HOW DID INJURY OCCUR? | |

22. I hereby certify that I attended the deceased from *Sept. 1*, 19*49*, to *Jan. 16*, 19*51*, that I last saw the deceased alive on *Jan. 16*, 19*51*, and that death occurred at *12:30 A.* m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

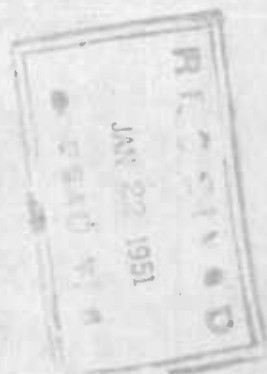
DATE SIGNED

| | | | | |
|---|---|---|---|--|
| 23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i> | | DATE THEREOF <i>Jan. 18, 1951</i> | NAME OF CEMETERY OR CREMATORY <i>Brookview Cemetery</i> | LOCATION (City, town, or county) (State) <i>Brookview Maryland</i> |
| DATE REC'D BY LOCAL REG. <i>1-17-51</i> | REGISTRAR'S SIGNATURE <i>Mary W. Holloray</i> | 24. FUNERAL DIRECTOR <i>J. J. Frampton and Son, Federalburg Md.</i> | | ADDRESS <i>✓</i> |

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

| | | | |
|--|-------------------------------|---|--|
| 1. PLACE OF DEATH COUNTY <u>McCombs</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>P.B. Hoyt</u> | | 2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>McCombs</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> STREET ADDRESS (If rural, give location) <u>223 East Locust St</u> | |
| 3. NAME OF DECEASED (Type or Print) <u>Henrietta</u> (First) (Middle) (Last) <u>Hammond</u> | | 4. DATE OF DEATH <u>Jan. 19 - 1951</u> (Month) (Day) (Year) | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH <u>Jan. 14 - 1857</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u> | 9. AGE last birthday <u>94</u> yrs. If under 1 year Months Days Hours Min. |
| 11. BIRTHPLACE (State or foreign country) <u>Salisbury Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Billie Parker</u> | | 14. MOTHER'S MAIDEN NAME <u>Hettie Middleton</u> | |
| 15. Was DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY No. | |
| 17. INFORMANT AND ADDRESS <u>Mrs. Virginia H. Pollitt Daughton</u> | | | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | |
|--|---|
| 420.1 Immediate cause (a) <u>Coronary Insufficiency</u> | INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Arteriosclerosis</u> | |
| 94a (c) <u>Arteriosclerotic gangrene of leg</u> | |

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

| | | |
|--|---|--|
| 19a. DATE OF OPERATION <u>1/16/51</u> | 19b. MAJOR FINDINGS OF OPERATION <u>Arteriosclerotic gangrene right leg</u> | 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) (COUNTY) (STATE) |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> | HOW DID INJURY OCCUR? |

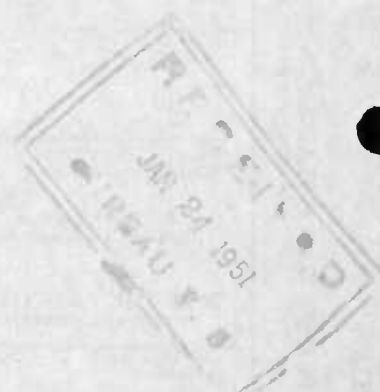
22. I hereby certify that I attended the deceased from 1/10, 1951, to 1/19, 1951, that I last saw the deceased alive on 1/19, 1951, and that death occurred at 10 a.m., from the causes and on the date stated above.

SIGNATURE Dr. R. G. Quamess M.D. ADDRESS Salisbury Md. DATE SIGNED 2/20/51

| | | | |
|---|---|--|---|
| 23. BURIAL CREMATION REMOVAL (Specify) | DATE THEREOF <u>Jan. 21-51</u> | NAME OF CEMETERY OR CREMATOR <u>Hammond Cem.</u> | LOCATION (City, town, or county) (State) <u>Salisbury Md.</u> |
| DATE REC'D BY LOCAL REG. <u>1-20-51</u> | REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u> | 24. FUNERAL DIRECTOR <u>Holloway & G. Saliby</u> | ADDRESS <u>Md.</u> |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH COUNTY <u>McKinnis</u> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Ind</u> COUNTY <u>McKinnis</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u> | |
| TOWN <u>Laurel</u> | | TOWN <u>Laurel</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1 P.B. Hryt.</u> | | STREET ADDRESS <u>PO # 2</u> (If rural give location) | |
| 3. NAME OF DECEASED (Type or Print) | (First) <u>Eda</u> | (Middle) <u>Ellen</u> | (Last) <u>Hastings</u> |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH <u>Oct. 29th 1886</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u> | 9. AGE last birthday <u>63</u> yrs. | 4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 25 - 51</u> |
| 11. BIRTHPLACE (State or foreign country) <u>W. Va.</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | 13. FATHER'S NAME <u>Harley J. Parker</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Nancy Jones</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | |
| 16. SOCIAL SECURITY NO. <u>PO # 2. Paralyzed Ind.</u> | | 17. INFORMANT <u>Mrs. Thomas Morris (daughter)</u> | |

| | | | |
|---|--|-------------------------------|----------------------------------|
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | 18. MEDICAL CERTIFICATION | INTERVAL BETWEEN ONSET AND DEATH |
| Immediate cause (a) <u>Coronary Heart Failure</u> | | <u>PO # 2. Paralyzed Ind.</u> | |
| Antecedent cause(s) (b) <u>Coronary Thrombosis</u> | | | |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) | | | |
| 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | |

| | | |
|--|---|--|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) (COUNTY) (STATE) |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> | HOW DID INJURY OCCUR? |

| | | | |
|---|--|--------------------------------|--|
| 22. I hereby certify that I attended the deceased from <u>Jan 23, 1957</u> , to <u>Jan 23, 1957</u> that I last saw the deceased alive on <u>Jan 23, 1957</u> , and that death occurred at <u>5:30 p.m.</u> , from the causes and on the date stated above. | | | |
| SIGNATURE <u>Carrie J. Hearn MD</u> | | DATE SIGNED <u>1/26/57</u> | |
| 23. BURIAL, CREMATION REMOVAL (Specify) | | NAME OF CEMETERY OR CREMATORY | |
| <u>Jan. 29-57 Laurel</u> | | <u>Laurel Md.</u> | |
| DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE | | 24. FUNERAL DIRECTOR ADDRESS | |
| <u>1-26-57 Mary W. Hollonay</u> | | <u>Hollonay Co. Laurel Md.</u> | |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

| | | | |
|---|----------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH - COUNTY <u>Wicomico</u> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Wicomico</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>903 Lake Street</u> | | STREET ADDRESS (If rural, give location) <u>903 Lake Street</u> | |
| 3. NAME OF DECEASED (Type or Print) <u>Simon</u> | | 4. DATE OF DEATH (Month) (Day) (Year) <u>1 - 3 - 1951</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>aa</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u> | 8. DATE OF BIRTH <u>8-16-1884</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>merchant</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>own store</u> | 9. AGE last birthday <u>66 yrs.</u> |
| 11. BIRTHPLACE (State or foreign country) <u>Salisbury, Wicomico Co. Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>William Horsey</u> | | 14. MOTHER'S MAIDEN NAME <u>Adeline Leonard</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>no</u> | |
| 17. INFORMANT AND ADDRESS <u>Mrs. Ethel Horsey, 903 Lake St. Salisbury, Md.</u> | | | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Coronary Occlusion

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arteriosclerotic Heart Disease

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

| | | | | |
|--|---|-----------------------|----------|---------|
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> | HOW DID INJURY OCCUR? | | |

22. I hereby certify that I attended the deceased from May 20, 1950, to Jan 3, 1951, that I last saw the deceased

alive on Jan 3, 1951, and that death occurred at 3:35 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

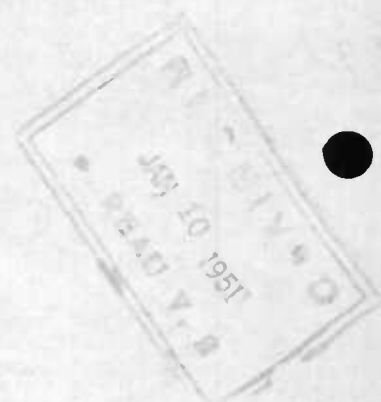
DATE SIGNED

| | | | |
|---|---|--|---|
| 23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u> | DATE THEREOF <u>1-7-51</u> | NAME OF CEMETERY OR CREMATORY <u>Green Acres Memorial Park</u> | LOCATION (City, town, or county, State) <u>Salisbury, Wicomico Co., Md.</u> |
| DATE REC'D BY LOCAL REG. <u>1-7-51</u> | REGISTRAR'S SIGNATURE <u>Mary W. Holloray</u> | 24. FUNERAL DIRECTOR <u>James B. Dashiell</u> | ADDRESS <u>2906 79 Salisbury, Md.</u> |

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0983 332 1.6

| | | | |
|---|---------------------------|--|---|
| 1. PLACE OF DEATH COUNTY <u>Wicomico</u> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Dorchester</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>East New Market</u> | |
| TOWN <u>Salisbury</u> LENGTH OF STAY (In this place) <u>1.5 mo</u> | | TOWN <u>East New Market</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Gar's Head State Hosp.</u> | | STREET ADDRESS (If rural, give location) <u>None</u> | |
| 3. NAME OF DECEASED (First) <u>Fannie</u> (Middle) <u>Virginia</u> (Last) <u>Jackson</u> | | 4. DATE OF DEATH (Month) <u>Jan</u> (Day) <u>19</u> (Year) <u>1957</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u> | 8. DATE OF BIRTH <u>Jan. 25, 1879</u> 71 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> |
| 13. FATHER'S NAME <u>George Jackson</u> | | 14. MOTHER'S MAIDEN NAME <u>Amanda Dunn</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY No. | |
| | | 17. INFORMANT AND ADDRESS <u>Hospital Record</u> | |

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443x

Immediate cause

(a) Arteriosclerotic Cardiovascular disease with Hypertension

INTERVAL BETWEEN ONSET AND DEATH

3 yrs.

Antecedent cause(s)

92d

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arteriosclerosis, General

unknown

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death

Hypertrophic arthritis of spine

3 yrs.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 5, 1950, to Jan. 19, 1951, that I last saw the deceased

alive on Jan. 19, 1951, and that death occurred at 8:15 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Carl A. Pass, M.D.

Gar's Head State Hosp. Salisbury Md. 1/19/51

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Jan. 21, 1951

John M. Mason, M.D.

LeCompte Funeral Service

1-24-51

Mary W. Holloway

Cambridge, Maryland

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH- COUNTY <u>Wicomico</u> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Worcester</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Ocean City Berlin R.D.</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u> | | STREET ADDRESS (If rural, give location) | |
| 3. NAME OF DECEASED (Type or Print) | (First) <u>Levin</u> (Middle) <u>Randall</u> (Last) <u>Jarmon</u> | 4. DATE OF DEATH | (Month) <u>January</u> (Day) <u>6</u> (Year) <u>1951</u> |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH <u>June 7, 1903</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home Plant</u> | 9. AGE last birthday <u>47</u> yrs. <u>7</u> months <u>0</u> days <u>0</u> hours <u>0</u> min. |
| 11. BIRTHPLACE (State or foreign country) <u>Delaware</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>unknown</u> | | 14. MOTHER'S MAIDEN NAME <u>Seguin Jarmon</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>unknown</u> | | 16. SOCIAL SECURITY NO. <u>21412-6948</u> | |
| 17. INFORMANT AND ADDRESS <u>Mrs. Levin Jarmon Berlin Md R.D.</u> | | | |

18. MEDICAL CERTIFICATION

| | |
|--|----------------------------------|
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | INTERVAL BETWEEN ONSET AND DEATH |
| 415x Immediate cause (a) <u>Myocardial Insufficiency</u> | <u>3 yrs.</u> |
| 95b Antecedent cause(s) (b) <u>Rheumatic Heart Disease</u> | <u>3 yrs.</u> |
| (c) | |

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

| | | |
|--|--|--|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) (COUNTY) (STATE) |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | HOW DID INJURY OCCUR? |

22. I hereby certify that I attended the deceased from Jan. 6, 1951, to Jan. 6, 1951, that I last saw the deceased alive on Jan. 6, 1951 and that death occurred at 9:45 P. m., from the causes and on the date stated above.

| | | | |
|---|---|--|--|
| SIGNATURE <u>David J. Silvers</u> | (Degree or title) <u>M.D.</u> | ADDRESS <u>Salisbury Md.</u> | DATE SIGNED <u>Jan 7, 1951</u> |
| 23. BURIAL, CREMATION REMOVAL (Specify) <u>Buried</u> | DATE THEREOF <u>1/9/51</u> | NAME OF CEMETERY OR CREMATORY <u>Riverside</u> | LOCATION (City, town, or county) (State) <u>Berlin Md R.D.</u> |
| DATE REC'D BY LOCAL REG. <u>1-15-50</u> | REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u> | 24. FUNERAL DIRECTOR <u>Anna D. Bunby</u> | ADDRESS <u>Berlin Md</u> |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

RECEIVED
JAN 15 1951
U. S. DEPT. OF AGRICULTURE

Dr. Noek

1985

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

| | | | |
|--|--|---|--------------------------------------|
| 1. PLACE OF DEATH: COUNTY <u>McCombs</u> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Md</u> COUNTY <u>McCombs</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Safety</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Safety</u> | |
| TOWN <u>Safety</u> | | TOWN <u>Safety</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>406 Dilghman St.</u> | | STREET ADDRESS <u>406</u> (If rural, give location) <u>Dilghman St.</u> | |
| 3. NAME OF DECEASED (Type or Print) | (First) <u>Herman</u> (Middle) <u>C.</u> (Last) <u>Johnson</u> | 4. DATE OF DEATH (Month) <u>Jan</u> (Day) <u>16</u> (Year) <u>1985</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH <u>Oct. 12-1884</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Builder</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Accomac Co. Va.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>John Johnson</u> | | 14. MOTHER'S MAIDEN NAME <u>Hester Aydelotte</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, Unknown) <u>No</u> | | 16. SOCIAL SECURITY No. <u></u> | |
| 17. INFORMANT <u>Mrs. Mildred Ellen (daughter)</u> | | | |

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

18. MEDICAL CERTIFICATION Sequel of Delirium

INTERVAL BETWEEN ONSET AND DEATH 2 hrs

Immediate cause

(a)

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

| | | | | |
|----------------------------------|---|-----------------------|----------|---------|
| 21. ACCIDENT (Specify) | PLACE (Home, farm, factory, street, office hldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE) |
| SUICIDE | INJURY | | | |
| HOMICIDE | | | | |
| TIME (Month) (Day) (Year) (Hour) | INJURY OCCURRED | HOW DID INJURY OCCUR? | | |
| OF | While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> | | | |
| INJURY | m. | | | |

22. I hereby certify that I attended the deceased from 1/10, 1985, to 1/16, 1985, that I last saw the deceasedalive on 1/16, 1985, and that death occurred at 5:30 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

| | | | | |
|--|-------------------------|--------------------------------------|----------------------------------|---------|
| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State) |
| <u>Removal</u> | <u>Jan. 19-85</u> | <u>McCombs Mem. Park</u> | <u>Safety Md.</u> | |
| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS | |
| <u>1-19-85</u> | <u>Mary W. Holloway</u> | <u>Holloway & Co. Safety Md.</u> | <u>Walter R. Holloway 510246</u> | |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 28 1951
U.S. AIR FORCE

Evidence for change
of age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

0986

CERTIFICATE OF DEATH

Reg. Dist. No. 332

FILE No. G 130 JAN 16 1951

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH: COUNTY <u>Wicomico</u> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Wic.</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Salisbury</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Salisbury</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula Gen. Hosp.</u> | | STREET ADDRESS (If rural, give location) | |
| 3. NAME OF DECEASED (First) (Middle) (Last) <u>MANIUS EVERETT Johnson</u> | | 4. DATE OF DEATH (Month) (Day) (Year) <u>1 5 1951</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u> | 8. DATE OF BIRTH <u>JAN. 1 1873</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Share Owner</u> | 9. AGE last birthday <u>76 78 yrs.</u> |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Benjamin Johnson</u> | | 14. MOTHER'S MAIDEN NAME | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | |
| 17. INFORMANT AND ADDRESS <u>Mrs. Jessie P. Johnson</u> | | | |

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Arteriosclerosis & Hypertension

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

97

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.)

TIME (Month) (Day) (Year) (Hour) OF INJURY m. INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-14, 1950, to 1-5, 1951, that I last saw the deceased

alive on 1-5, 1951, and that death occurred at 5:15 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

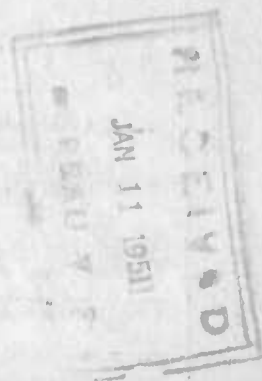
ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

290116



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

Dr. Robbins

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0987 332

| | | | |
|---|-------------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH- COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Wicomico | |
| CITY (If outside corporate limits, write RURAL and give nearest town) Pittsville | | CITY (If outside corporate limits, write RURAL and give nearest town) Pittsville | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS R. D. # 2 | | STREET ADDRESS (If rural, give location) R. D. # 2 | |
| 3. NAME OF DECEASED (Type or Print) | (First) Annie | (Middle) P | (Last) Jones |
| 4. DATE OF DEATH | (Month) Jan. | (Day) 4 | (Year) 1951 |
| 5. SEX Female | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed | 8. DATE OF BIRTH April 28-1877 |
| 9. AGE last birthday 73 yrs. | | 10. If under 1 year Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife | | 10b. KIND OF BUSINESS OR INDUSTRY At Own Home | |
| 11. BIRTHPLACE (State or foreign country) Powellville Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Silas Bailey | | 14. MOTHER'S MAIDEN NAME Mary Hester Brittingham | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY No. (If yes, give war or dates of service) | |
| 17. INFORMANT AND ADDRESS Mr. Roger Jones (SON) | | | |

18. MEDICAL CERTIFICATION **R.D. # 2 Pittsville Md.** INTERVAL BETWEEN ONSET AND DEATH

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) **Acute Cardiac Decompensation with Anasarca 4 days**

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) **se Chronic Dysentery Myocarditis 3 yrs**

(c) **Asthma Bronchiale Senilis 15 yrs**

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

| | | |
|--|---|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 21. ACCIDENT (Specify) SUICIDE | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) (COUNTY) (STATE) |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> | HOW DID INJURY OCCUR? |

22. I hereby certify that I attended the deceased from **3 Jan.**, 19**51**, to **4 Jan.**, 19**51**, that I last saw the deceased alive on **4 Jan.**, 19**51**, and that death occurred at **1:15 A.** m., from the causes and on the date stated above.

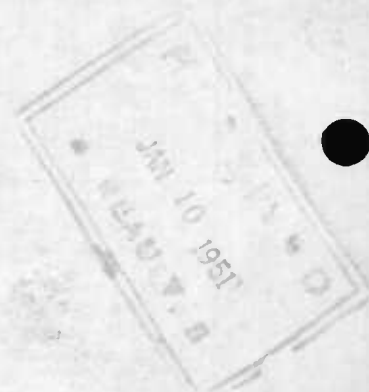
SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

| | | | |
|---|---|---|--|
| 23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE THEREOF Jan. 7 -1951 | NAME OF CEMETERY OR CREMATORY Mt. Pleasant Cem. | LOCATION (City, town, or county) (State) Near Powellville Md. |
| DATE REC'D BY LOCAL REG. 1-6-51 | REGISTRAR'S SIGNATURE Mary W. Holloway | 24. FUNERAL DIRECTOR Holloway & Company - Salisbury, Md. | ADDRESS Walter R. Holloway |



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

0988

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|-------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH- COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Wicomico | |
| CITY (If outside corporate limits, write RURAL and give nearest town) Head of the Creek | | CITY (If outside corporate limits, write RURAL and give nearest town) Head of the Creek | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS at home | | STREET ADDRESS (If rural, give location) Quantico, Md. Rt. #1 | |
| 3. NAME OF DECEASED (Type or Print) William Brothen Jones | | 4. DATE OF DEATH Month January Day 23 Year 1951 | |
| 5. SEX Male | 6. COLOR OR RACE AA | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married | 8. DATE OF BIRTH 8-10-1875 |
| 9. AGE last birthday 75 yrs. | | 10. If under 1 year Months 5 Days 13 Hours 13 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Own Farm | |
| 11. BIRTHPLACE (State or foreign country) Head of the Creek, Wic. Co. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME unknown | | 14. MOTHER'S MAIDEN NAME Rosetta Goslee | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY No. no | |
| 17. INFORMANT AND ADDRESS Mrs. Mabel M. Waters, Quantico, Md. Rt. #1 | | | |

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) **Cerebral hemorrhage**

INTERVAL BETWEEN ONSET AND DEATH

4 days

Antecedent cause(s) (b)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c) **Arteriosclerosis**

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

| | | | | |
|--|---|-----------------------|----------|---------|
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> | HOW DID INJURY OCCUR? | | |

22. I hereby certify that I attended the deceased from **Jan 20**, 19**51**, to **Jan 23**, 19**51**, that I last saw the deceased

alive on **Jan 22**, 19**51**, and that death occurred at **11:50 p.m.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

William E. Enrich M.D.

Helsov - Md.

Jan 25-51

| | | | |
|--|--|--|--|
| 23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE THEREOF 1-26-51 | NAME OF CEMETERY OR CREMATORY St. James Cem. | LOCATION (City, town, or county) Head of the Creek, Wic. Co. Md. |
| DATE REC'D BY LOCAL REG. 1-26-51 | REGISTRAR'S SIGNATURE Mary W. Holloway | 24. FUNERAL DIRECTOR James B. Dashiell, Salisbury, Md. | ADDRESS 100105 |

1-29-51

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

| | | | |
|--|---------------------------------------|---|--|
| 1. PLACE OF DEATH COUNTY <u>Wicomico</u> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Wicomico</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u> | | STREET ADDRESS (If rural, give location) | |
| 3. NAME OF DECEASED (Type or Print) | (First) <u>George</u> | (Middle) <u>Edwin</u> | (Last) <u>Joyce</u> |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>colored</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 4. DATE OF DEATH <u>January 12 1957</u> |
| 8. DATE OF BIRTH <u>1-12-51</u> | 9. AGE last birthday <u>6</u> yrs. | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME <u>Delores Jeannette Joyce</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY No. | |
| 17. INFORMANT AND ADDRESS | | | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) prematurity

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

| | | | | |
|--|---|-----------------------|----------|---------|
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> | HOW DID INJURY OCCUR? | | |

22. I hereby certify that I attended the deceased from 1/10/57, 1957, to 1/12, 1957, that I last saw the deceased alive on 1/12, 1957, and that death occurred at 5:15 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

| | | | | |
|---|-------------------------|-----------------------------------|----------------------------------|----------------|
| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State) |
| <u>1-13-57</u> | <u>1/13/57</u> | <u>Peninsula General Hospital</u> | <u>Salisbury, Md.</u> | <u>1-13-57</u> |
| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS | |
| <u>1-15-57</u> | <u>Marjell Holloway</u> | <u>Peninsula General Hospital</u> | <u>Salisbury, Md.</u> | |

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY

OFFICE OF THE CHIEF OF THE BUREAU OF THE ARMY

RECEIVED
JUN 18 1951
READ V 2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change in MARYLAND STATE DEPARTMENT OF HEALTH
#8 shown on: 2411 N. Charles Street, Baltimore

FILM No. G 130 JAN 19 1951 CERTIFICATE OF DEATH

Reg. Dist. No. 332

| | | | |
|---|-------------------------------|---|---|
| 1. PLACE OF DEATH COUNTY <u>Wicomico</u> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u> | |
| CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Salisbury</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hosp</u> | | STREET ADDRESS (If rural, give location) <u>1412 S. Hanover Street</u> | |
| 3. NAME OF DECEASED (Type or Print) | (First) <u>Joseph</u> | (Middle) | (Last) <u>Kamp</u> |
| 5. SEX <u>m.</u> | 6. COLOR OR RACE <u>white</u> | 7. SINGLE, <input checked="" type="checkbox"/> MARRIED WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH <u>Sept. 7, 1896</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Butcher</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE last birthday <u>55</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min. |
| 11. FATHER'S NAME <u>Joseph Kamp</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13. MOTHER'S MAIDEN NAME <u>Unknown</u> | | 14. DATE OF DEATH <u>Jan. 13, 1951</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u> | | 16. SOCIAL SECURITY No. <u>none</u> | |
| 17. INFORMANT AND ADDRESS <u>Hospital Record</u> | | | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

163x

Immediate cause

(a)

Carcinoma of the lung

INTERVAL BETWEEN ONSET AND DEATH
~ 2.5 mo.

47d

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Secondary anemia

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐
(STATE)

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Not While Work ☐ At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 19, 1950, to Jan. 13, 1951, that I last saw the deceased alive on Jan. 13, 1951, and that death occurred at 1:30 A. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Arrel A. Paar M.D.

Deer's Head State Hosp. Salisbury Md. 1/13/51

Buried

Jan. 16, 1951

Green Haven

Baltimore Md.

1-15-51

Mary W. Holloway

The Hill & Johnson Co.

George C. Hill #6900W



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. **336**

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH- COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED- STATE MD COUNTY Wicomico | |
| CITY (If outside corporate limits, write RURAL and give nearest town) TOWN DELMAR | | CITY (If outside corporate limits, write RURAL and give nearest town) TOWN MARDELA SPRINGS | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS FRIENDLY NURSING HOME | | STREET ADDRESS (If rural, give location) | |
| 3. NAME OF DECEASED (Type or Print) | (First) BERTIE | (Middle) ELLEN | (Last) LLOYD |
| 4. DATE OF DEATH | (Month) 1 | (Day) 25 | (Year) 1951 |
| 5. SEX F | 6. COLOR OR RACE W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED | 8. DATE OF BIRTH OCT 16, 1866 |
| 9. AGE last birthday 84 yrs. | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | 10b. KIND OF BUSINESS OR INDUSTRY NONE | 11. BIRTHPLACE (State or foreign country) MD |
| 12. CITIZEN OF WHAT COUNTRY? | 13. FATHER'S NAME JOHN HORSEMAN | 14. MOTHER'S MAIDEN NAME SALLIE ANN BROWN | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO | 16. SOCIAL SECURITY NO. NONE | 17. INFORMANT AND ADDRESS MRS THOMAS SHOCKLEY | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.2 Immediate cause

(a) **Acute Myocardial Cardiac Failure**

INTERVAL BETWEEN ONSET AND DEATH

2 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) **Chronic Myocarditis****3 yrs**(c) **Chronic Hypertitis****2 yrs**

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Jan. 1, 1951**, to **Jan. 25, 1951**, that I last saw the deceasedalive on **Jan. 24, 1951**, and that death occurred at **12:30 p.m.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

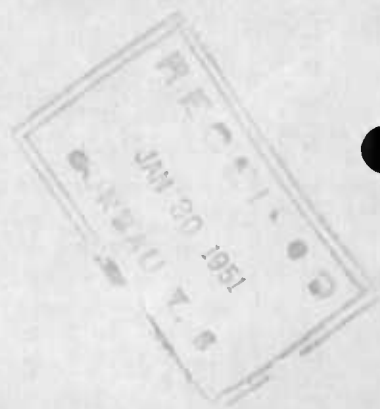
ADDRESS

January 28, 51 Harry E. Hudson**Delmar Del Mardele md Paul J. Smith, Shaptown md**

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

| | | | |
|---|-------------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH - COUNTY <u>Wicomico</u> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Somerset</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Westover</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u> | | STREET ADDRESS (If rural, give location) <u>P.O.</u> | |
| 3. NAME OF DECEASED (Last, first or Print) <u>Robert Milton</u> | | 4. DATE OF DEATH (Month) (Day) (Year) <u>January 14 1951</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>Feb. 8 - 1876</u> |
| 9. AGE last birthday <u>74</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done the greatest part of working life or if retired) <u>Farmer</u> | |
| 11. FATHER'S NAME <u>Robert Ballard Matthews</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. MOTHER'S MAIDEN NAME <u>Sarah Elizabeth Foster</u> | | 14. BIRTHPLACE (State or foreign country) <u>Westover Maryland</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u> | | 16. SOCIAL SECURITY No. <u>351 New York Ave Salisbury Md.</u> | |
| 17. INFORMANT AND ADDRESS <u>Mr. Elizabeth Donohoe (Daughter)</u> | | 18. MEDICAL CERTIFICATION | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 449x Immediate cause (a) <u>Extra-cranial Hemorrhage</u> | | | |
| 93d Antecedent cause(s) (b) <u>Hypertensive C.V. disease</u> | | | |
| (c) <u>giving rise to the above cause stating the underlying cause last</u> | | | |
| II. OTHER SIGNIFICANT CONDITIONS | | | |
| Conditions contributing to the death but not related to the disease or condition causing death. | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/> | | | |
| 21. ACCIDENT (Specify) SUICIDE HOMICIDE | | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> | |
| | | HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <u>1/12</u> , 19 <u>50</u> , to <u>1/14</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>1/14</u> , 19 <u>51</u> , and that death occurred at <u>8 P.m.</u> , from the causes and on the date stated above. | | | |
| SIGNATURE <u>W. B. Smith M.D.</u> | | ADDRESS <u>Salisbury, Md</u> | |
| DATE SIGNED <u>1/14/51</u> | | | |
| 23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u> | | DATE THEREOF <u>Jan. 17-51</u> | |
| NAME OF CEMETERY OR CREMATORY <u>McComie Burial</u> | | LOCATION (City, town, county) <u>Salisbury Md.</u> | |
| DATE REC'D BY LOCAL REG. <u>1-15-51</u> | | REGISTRAR'S SIGNATURE <u>Mary W. Hollonay</u> | |
| | | 24. FUNERAL DIRECTOR <u>Hollonay & Co. Salisbury Md.</u> | |
| | | ADDRESS <u>Salisbury Md.</u> | |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

970307

RECEIVED

RECEIVED

RECEIVED
JUN 18 1951
U.S. AIR FORCE

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

0993

Reg. Dist. No. 332

| | | | |
|--|-------------------------------|--|---|
| 1. PLACE OF DEATH- COUNTY <u>Wicomico</u> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Wicomico</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury, Rural</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Quantico Bay 72</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | STREET ADDRESS (If rural give location) | |
| 3. NAME OF DECEASED (Type or Print) (First) <u>Steven</u> (Middle) <u>Miller</u> (Last) | | 4. DATE OF DEATH (Month) <u>Jan.</u> (Day) <u>8th</u> (Year) <u>1957</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u> | 8. DATE OF BIRTH (Specify) <u>Oct. 10, 1889</u> 61 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>lumberman</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>lumber</u> | 11. BIRTHPLACE (State or foreign country) <u>Cleveland Ohio</u> |
| 13. FATHER'S NAME <u>Steven Miller</u> | | 14. MOTHER'S MAIDEN NAME <u>Bertie King</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY No. <u>137-12-088</u> | |
| 17. INFORMANT <u>Mrs. Steven Miller, Quantico, Md.</u> | | | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

910.3 Immediate cause

(a) Fracture of Cervical Vertebra

Antecedent cause(s)

186b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

INTERVAL BETWEEN ONSET AND DEATH
Sudden

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING ☐ PLACE (Home, farm, factory, street, or office, etc.) factory CITY OR TOWN Salisbury Rural (COUNTY) Wicomico (STATE) Md.

TIME (Month) (Day) (Year) (Hour) INJURY OCCURRED Jan 8, 1957 3:45 PM WHILE AT ☒ work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

Crushed by falling log.

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☐ Inquiry ☒ Thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Oliver G. Fisher M.D. 300 N. Wisconsin St. Salisbury Md. 1/8/57

23. BURIAL, CREMATION OR REMOVAL (Specify) Burial DATE THEREOF 1-11-1957 NAME OF CEMETERY OR CREMATORY Parson Cemetery LOCATION (City, town, or county) Salisbury Md. (State)

DATE REC'D BY LOCAL REG. 1-11-57 REGISTRAR'S SIGNATURE Mary W. Hollonay 24. FUNERAL DIRECTOR Levin B. Wilson ADDRESS Princess Anne Md.

920907

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Mrs Mary Halloway



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH COUNTY <u>Wicomico</u> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Wicomico</u> | |
| CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Nebron</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Nebron</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>William</u> | | STREET ADDRESS (If rural, give location) | |
| 3. NAME OF DECEASED (Type or Print) | (First) | (Middle) | (Last) |
| <u>WILLIAM</u> | <u>HENRY</u> | <u>MITCHELL, Jr.</u> | |
| 6. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u> | 4. DATE OF DEATH (Month) (Day) (Year) <u>1</u> <u>16</u> <u>1951</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>Canning factory</u> | 8. DATE OF BIRTH <u>Sept. 15, 1897</u> | 9. AGE last birthday <u>53</u> yrs. |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | |
| 13. FATHER'S NAME <u>William W. Mitchell</u> | 14. MOTHER'S MAIDEN NAME <u>Lilla Phelps</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | 17. INFORMANT AND ADDRESS <u>Frank Mitchell</u> | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

331x Immediate cause (a)

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 1, 1947, to June 16, 1951, that I last saw the deceasedalive on June 16, 1951, and that death occurred at 1:45 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REBURYAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

523408



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH- COUNTY <u>Wicomico</u> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Wicomico</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Delmar</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u> | | STREET ADDRESS <u>2 South First Street</u> | |
| 3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Craig</u> <u>Lynn</u> <u>Northrup</u> | | 4. DATE OF DEATH (Month) (Day) (Year) <u>January</u> <u>31</u> <u>1951</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, SEPARATED (Specify) <u>Single</u> | 8. DATE OF BIRTH <u>Jan. 20, 1951</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | 9. AGE last birthday If under 1 year Months <u>11</u> Days <u>11</u> Hours <u>—</u> Min. <u>—</u> |
| 11. BIRTHPLACE (State or foreign country) <u>Salisbury, Maryland</u> | | 12. CITIZEN OF WHAT <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Malcolm T. Northrup</u> | | 14. MOTHER'S MAIDEN NAME <u>Virginia Irene Butler</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY No. <u>None</u> | |
| 17. INFORMANT AND ADDRESS <u>Malcolm T. Northrup, Delmar, Md.</u> | | | |

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

154.5 Immediate cause

(a)

Coarctation of the aorta (infantile type)

INTERVAL BETWEEN ONSET AND DEATH

congenital

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.Patent intra-Ventricular septal defect - congenital

| | | | | | |
|--|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | | PLACE (Home, farm, factory, street, OF injury bldg., etc.) | | (CITY OR TOWN) (COUNTY) (STATE) | |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> | | HOW DID INJURY OCCUR? | |

22. I hereby certify that I attended the deceased from Jan 30, 1951, to Jan 31, 1951, that I last saw the deceasedalive on Jan 31, 1951, and that death occurred at 5:05 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

| | | | | |
|--|--|--|---|---|
| 23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u> | | DATE THEREOF <u>Feb. 2, 1951</u> | NAME OF CEMETERY OR CREMATORY <u>Washington Cemetery</u> | LOCATION (City, town, or county) (State) <u>Near Hurlock, Maryland</u> |
| DATE REC'D BY LOCAL REG. <u>2-3-51</u> | | REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u> | | 24. FUNERAL DIRECTOR <u>J. J. Frampton and Son, Federalsburg, Md.</u> |

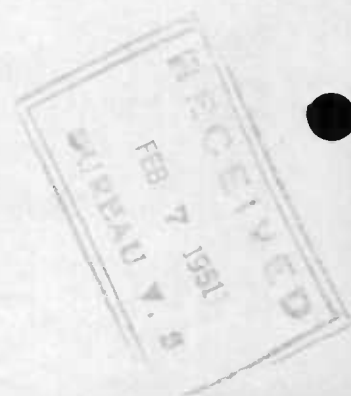
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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

Correct age



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH COUNTY <u>Wicomico</u> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Wicomico</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u> | | STREET ADDRESS (If rural, give location) <u>Burleigh St</u> | |
| 3. NAME OF DECEASED (Type or Print) | (First) <u>Harry</u> | (Middle) <u>Chlor</u> | (Last) <u>Palmer</u> |
| 4. DATE OF DEATH | (Month) <u>January</u> | (Day) <u>9</u> | (Year) <u>1957</u> |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u> | 8. DATE OF BIRTH <u>Feb. 3, 1870</u> |
| 9. AGE last birthday <u>86</u> yrs. | If under 1 year Months <u>11</u> Days <u>6</u> | If under 24 hrs. Hours <u>11</u> Min. <u>6</u> | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper & Secretary</u> |
| 10b. KIND OF BUSINESS OR INDUSTRY <u>Berlin Bldg. Co.</u> | 11. BIRTHPLACE (State or foreign country) <u>Chincoteague, Va.</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>John O. Palmer</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary Cooper</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY No. <u>no</u> | |
| 17. INFORMANT AND ADDRESS <u>Mrs. Sister Palmer Berlin Md</u> | | | |

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331 x Immediate cause (a) Cerebral Hemorrhage
Antecedent cause(s) (b) Cerebral Arteriosclerosis
33d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Athemia

INTERVAL BETWEEN ONSET AND DEATH

3 hrs.
1 yr.
2 weeks

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Myocardial Insufficiency

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-21, 1950, to 1-9, 1951, that I last saw the deceased

alive on 1-9-1951, and that death occurred at 10:20 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

1-15-51

Mary W. Holloway

Anna H. Burby Berlin Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

310716



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH COUNTY <u>McComick</u> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD.</u> COUNTY <u>McComick</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | |
| TOWN <u>Salisbury</u> | | TOWN <u>Salisbury</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>RD #2</u> | | STREET ADDRESS (If rural, give location) <u>RD #2</u> | |
| 3. NAME OF DECEASED (Type or Print) <u>Oleria Mae Parone</u> | | 4. DATE OF DEATH (Month) <u>Jan</u> (Day) <u>27</u> (Year) <u>1951</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, DIVORCED, WIDOWED, REWIDOWED, (Specify) | 8. DATE OF BIRTH <u>May 2-1886</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE last birthday <u>64</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min. |
| 11. BIRTH PLACE (State or foreign country) <u>Pittsville Md.</u> | | 12. CITIZENSHIP OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Joseph Brown</u> | | 14. MOTHER'S MAIDEN NAME <u>Ganey Elliott</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| (If year, give war or dates of service) | | 17. INFORMANT <u>Dr. Stephen Parone</u> | |
| 18. MEDICAL CERTIFICATION | | | INTERVAL BETWEEN ONSET AND DEATH |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | |
| Immediate cause (a) <u>Acute Bronchitis</u> | | | <u>24 hrs</u> |
| Antecedent cause(s) (b) <u>Infection of both lungs</u> | | | <u>10 yrs</u> |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) | | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | |
| 21. ACCIDENT (Specify) SUICIDE HOMICIDE | | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | |
| (CITY OR TOWN) | | (COUNTY) (STATE) | |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> | |
| HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Jan 26</u> , 19 <u>51</u> , to <u>Jan 27</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>Jan 26</u> , 19 <u>51</u> , and that death occurred at <u>12:30 a.m.</u> , from the causes and on the date stated above. | | | |
| SIGNATURE <u>Dr. Lynch</u> | | ADDRESS <u>Salisbury Md.</u> | |
| DATE SIGNED <u>Jan 30-51</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify) | | NAME OF CEMETERY OR CREMATORY | |
| DATE <u>Jan 30-51</u> | | LOCATION (City, town, or county) (State) | |
| DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u> | | 24. FUNERAL DIRECTOR <u>Holloway & Son</u> | |
| REG. <u>1-30-51</u> | | ADDRESS <u>Salisbury Md.</u> | |

RECEIVED
FEB 2 1951
U.S. AIR FORCE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

0998

Reg. Dist. No. 332

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH COUNTY <u>McComick</u> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>McComick</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>210 E. Church St.</u> | | STREET ADDRESS (If rural, give location) <u>210 E. Church St.</u> | |
| 3. NAME OF DECEASED (Type or Print) | (First) <u>Orlando</u> (Middle) <u>Chester</u> (Last) <u>Politt</u> | 4. DATE OF DEATH | (Month) <u>Jan</u> (Day) <u>5</u> (Year) <u>1951</u> |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH <u>March 28 - 1886</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>Eng. Construction</u> | 9. AGE last birthday <u>62</u> yrs. | 11. BIRTHPLACE (State or foreign country) <u>Maryland Md.</u> |
| 13. FATHER'S NAME <u>John S. Politt</u> | 14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Bailey</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | 16. SOCIAL SECURITY No. <u></u> | 17. INFORMANT AND ADDRESS <u>My. J. Politt (son)</u> | |
| 18. MEDICAL CERTIFICATION | | | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | INTERVAL BETWEEN ONSET AND DEATH |
| Immediate cause (a) <u>Coronary Occlusion</u> | | | <u>thru</u> |
| Antecedent cause(s) (b) <u>(sudden death)</u> | | | |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) | | | |
| 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | |
| 22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at <u>2:45 P</u> m., from the causes and on the date stated above. | | | |
| SIGNATURE <u>[Signature]</u> (Degree or title) <u>MD</u> | | ADDRESS <u>5047 N. Division St</u> DATE SIGNED <u>1-6-51</u> | |
| 23. BURIAL CREMATION REMOVAL (Specify) | DATE THEREOF <u>Jan. 8-51</u> | NAME OF CEMETERY OR CREMATORY <u>Harmon Cem.</u> | LOCATION (City, town, or county) (State) <u>Salisbury Md.</u> |
| DATE REC'D BY LOCAL REG. <u>1-6-51</u> | REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u> | 24. FUNERAL DIRECTOR <u>Holloway & Co. Salisbury Md.</u> | ADDRESS <u>Walter R. Holloway 510246</u> |

MARGIN RESERVED FOR BINDING

VS. A15

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U.S. DEPT. OF JUSTICE
FBI

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 999

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH - COUNTY <u>Wicomico</u> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Wicomico</u> | |
| CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Salisbury</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pittsville</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u> | | STREET ADDRESS (If rural, give location) | |
| 3. NAME OF DECEASED (Type or Print) | (First) <u>Patricia</u> (Middle) <u>Anna</u> (Last) <u>Powell</u> | 4. DATE OF DEATH | (Month) <u>January</u> (Day) <u>15</u> (Year) <u>1951</u> |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH <u>January 14 1911</u> yrs. Months <u>14</u> Days <u>30</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) <u>Salisbury, Md.</u> |
| 13. FATHER'S NAME <u>Mr. Ralph Edwin Powell</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary Virginia Turner</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY No. | |
| | | 17. INFORMANT AND ADDRESS | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

776x

Immediate cause

(a)

pneumonia

159

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/14, 1951, to 1/15, 1951, that I last saw the deceasedalive on 1/15, 1951, and that death occurred at 10:30 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

20114121/286

RECEIVED
JAN 19 1951
FBI

Dr. Brule

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 392

1000

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH COUNTY <u>Wicomico</u> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Wicomico</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>311. Baker St.</u> | | STREET ADDRESS (If rural give location) <u>311. Baker St.</u> | |
| 3. NAME OF DECEASED (Type or Print) <u>Albert</u> (First) <u>Washington</u> (Middle) <u>Purcell</u> (Last) | | 4. DATE OF DEATH (Month) (Day) (Year) <u>Jan.</u> <u>31</u> - <u>51</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH <u>Feb. 13-1883</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | 9. AGE last birthday <u>68</u> yrs. |
| 11. BIRTHPLACE (State or foreign country) <u>Salisbury Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Thomas Purcell</u> | | 14. MOTHER'S MAIDEN NAME <u>Martha Adama</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <u>No</u> | | 16. SOCIAL SECURITY No. | |
| 17. INFORMANT <u>Mr. Cassin B. Purcell (A/N)</u> | | | |

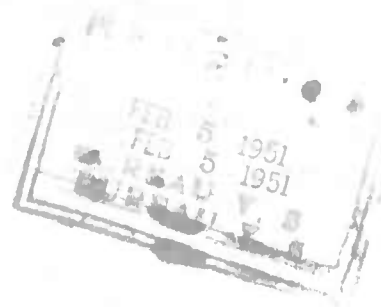
| | | | |
|---|--|--|--|
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | 18. MEDICAL CERTIFICATION <u>311. Baker St. Salisbury Md.</u> | INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u> |
| Immediate cause <u>422.1</u> <u>Arteriosclerotic gangrene left leg</u> | | (a) <u>Arteriosclerotic cardiovascular</u> | <u>10 yrs</u> |
| Antecedent cause(s) <u>93d</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | | (b) <u>Arteriosclerotic cardiovascular</u> | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | (c) <u>Arteriosclerotic</u> | |
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 21. ACCIDENT (Specify) SUICIDE HOMICIDE | PLACE (Home, farm, factory, street, office bldg., etc.) INJURY | (CITY OR TOWN) | (COUNTY) (STATE) |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> | HOW DID INJURY OCCUR? | |

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at....., 19....., from the causes and on the date stated above.

| | | | | |
|---|--|---|--|---------------------------------|
| SIGNATURE <u>Dr. Brule</u> | | ADDRESS <u>MD 5047 N. Quissip Rd</u> | | DATE SIGNED <u>2-1-51</u> |
| 23. BURIAL, CREMATION REMOVAL (Specify) <u>Feb. 3-51</u> | DATE | NAME OF CEMETERY OR CREMATORY <u>Harmon Cem.</u> | LOCATION (City, town, or county) <u>Salisbury Md.</u> | (State) |
| DATE REC'D BY LOCAL REG. <u>2-1-51</u> | REGISTRAR'S SIGNATURE <u>Harold W. Hollomay</u> | 24. FUNERAL DIRECTOR <u>Hollomay & Co.</u> | | ADDRESS <u>Salisbury Md.</u> |
| | | <u>Walter K. Hollomay</u> | | <u>970 VVV</u> |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1901

| | | | |
|---|---------------------------|--|----------------------------------|
| 1. PLACE OF DEATH COUNTY <u>Wicomico</u> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Wicomico</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u> | | STREET ADDRESS (If rural, give location) <u>602 Rose Street</u> | |
| 3. NAME OF DECEASED (First) <u>Leroy</u> (Middle) <u>James</u> (Last) <u>Quinton</u> | | 4. DATE OF DEATH (Month) <u>Jan.</u> (Day) <u>19</u> (Year) <u>1957</u> | |
| 5. SEX <u>m</u> | 6. COLOR OR RACE <u>E</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH <u>5/2/1897</u> |
| 9. AGE last birthday <u>53</u> yrs. | | 10. AGE last birthday If under 1 year Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <u>unknown</u> | | 14. MOTHER'S MAIDEN NAME <u>Georgianna Quinton</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY No. <u>217-10-3558</u> | |
| 17. INFORMANT AND ADDRESS <u>Hospital Record</u> | | | |

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Hypertensive cardiovascular disease

INTERVAL BETWEEN ONSET AND DEATH

unknown

Antecedent cause(s)

(b) Intra cerebral bleeding

-2 mo

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c) Extensive nervous system syphilis

unknown

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 13, 1957, to Jan. 19, 1957, that I last saw the deceased

alive on Jan. 19, 1957, and that death occurred at 2:22 A. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Asel A. Paas, M.D. Deer's Head Hosp, Salisbury, Md. 1/19/57

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

1-23-57 Mary W. Holloway Dorcas M. West Salisbury, Md.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY

OFFICE OF THE CHIEF OF THE BUREAU OF THE ARMY

WASHINGTON, D. C.

THE FOLLOWING INFORMATION IS FOR YOUR INFORMATION ONLY

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 386

| | | | |
|--|-------------------------------|---|-----------------------------------|
| 1. PLACE OF DEATH COUNTY <u>Wicomico</u> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Wicomico</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Delmar</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Delmar</u> | |
| TOWN <u>Delmar</u> | | TOWN <u>Delmar</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R 7 D # 31</u> | | STREET ADDRESS (If rural, give location) <u>R 7 D # 3</u> | |
| 3. NAME OF DECEASED (First) (Middle) (Last) <u>MAURICE COOPER REDDISH</u> | | 4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 1 1951</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>3-26-1915</u> |
| 9. AGE last birthday <u>35</u> yrs. | | 10. AGE last birthday (If under 1 year) (If under 24 hrs.) Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Delmar Md</u> | | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | |
| 13. FATHER'S NAME <u>Ernest Reddish</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary Ellen Cordry</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <u>No</u> | | 16. SOCIAL SECURITY No. <u>—</u> | |
| 17. INFORMANT AND ADDRESS <u>Shirley Rabbit - Delmar</u> | | | |

| | | |
|---|-------------------------------|----------------------------------|
| 18. MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | |
| Immediate cause | (a) <u>Coronary occlusion</u> | <u>30 min</u> |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) <u>Coronary sclerosis</u> | |
| | (c) | |

| | | |
|---|---|--|
| 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | |
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 21. ACCIDENT (Specify) SUICIDE HOMICIDE | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) (COUNTY) (STATE) |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> | HOW DID INJURY OCCUR? |

22. I hereby certify that I attended the deceased from 1-1, 1951, to 1-1, 1951, that I last saw the deceased alive on 1-1, 1951, and that death occurred at 9:00 P m., from the causes and on the date stated above.

SIGNATURE H.V. Sotler, M.D. ADDRESS Delmar, Del. DATE SIGNED Jan. 3rd 51.

| | | | |
|--|-----------------------|-------------------------------|--|
| 23. BURIAL CREMATION REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
| <u>Burial</u> | <u>1-4-51</u> | <u>M. P. Cemetery</u> | <u>Delmar, Del.</u> |
| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
| <u>Jan. 4, 1951</u> | <u>Harriet Hudson</u> | <u>W. S. Ward Co.</u> | <u>Delmar</u> |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 6 1981
BUREAU W. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Laury

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

1003

Reg. Dist. No. 332

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH- COUNTY <u>McComick</u> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD.</u> COUNTY <u>McComick</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>P.O. Hoyt.</u> | | STREET ADDRESS (If rural give location) <u>210. E. Church st.</u> | |
| 3. NAME OF DECEASED (Type or Print) <u>Roy</u> | (First) <u>Francis</u> | (Middle) <u>Reno</u> | (Last) |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH <u>May 12 - 1924</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u> | 9. AGE last birthday <u>48</u> yrs. |
| 11. BIRTH PLACE (State or foreign country) <u>Haywood, N.C.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>John C. Reno</u> | | 14. MOTHER'S MAIDEN NAME <u>Cora Williams</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> | | 16. SOCIAL SECURITY NO. <u>210 E. Church st.</u> | |
| 17. INFORMANT <u>Mr. Annabelle Reno (Wife)</u> | | | |

| | | | |
|---|--|---|--|
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | 18. MEDICAL CERTIFICATION <u>210 E. Church st.</u> <u>Salisbury Md.</u> | INTERVAL BETWEEN ONSET AND DEATH <u>2 da</u> |
| Immediate cause (a) <u>Coronary Thrombosis.</u> | | | |
| Antecedent cause(s) (b) <u>420.1</u> | | | |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>94a</u> | | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | |
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 21. ACCIDENT (Specify) SUICIDE HOMICIDE | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) | (COUNTY) (STATE) |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> | HOW DID INJURY OCCUR? | |

22. I hereby certify that I attended the deceased from 1-8, 1951, to 1-16, 1951, that I last saw the deceased alive on 1-16-51, 1951, and that death occurred at 805m, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION
REMOVAL (Specify)

DATE

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL
REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Lee L. Laury
Jan. 19-51
1-18-51.

Parson Cem.
Salisbury Md.
Mary W. Holloway
254679

Salisbury Md.
Holloway & Co. Salisbury Md.
Martin R. Holloway

U.S. A. D. 1951
JUL 11 1951
S. A. D. 1951

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

| | | | |
|--|-------------------------------|---|--|
| 1. PLACE OF DEATH - COUNTY <u>Wicomico</u> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Worcester</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury, Maryland</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u> | |
| TOWN <u>Salisbury, Maryland</u> | | TOWN <u>Berlin</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u> | | STREET ADDRESS (If rural, give location) <u>Rt D #12</u> | |
| 3. NAME OF DECEASED (First) <u>George</u> | (Middle) <u>Olva</u> | (Last) <u>Rolls</u> | 4. DATE OF DEATH (Month) <u>January</u> (Day) <u>15</u> (Year) <u>1951</u> |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u> | 8. DATE OF BIRTH <u>June 27, 1888</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Life Ins. Agent</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (last birthday) <u>62 yrs.</u> If under 1 year <u>18</u> Months <u>18</u> Days <u>18</u> Hours <u>18</u> Min. |
| 11. BIRTHPLACE (State or foreign country) <u>Berry, Missouri</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Edgar A. Rolls</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary Belle Gull</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>World War I</u> | | 16. SOCIAL SECURITY No. | |
| 17. INFORMANT AND ADDRESS <u>Mrs. George A. Rolls Berlin Md</u> | | 18. MEDICAL CERTIFICATION | |

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Hypertensive Cardiovascular

Antecedent cause(s)

(b) With acute Cardiac dilatation

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

None

21. ACCIDENT (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY?

Yes ☐ No ☒ (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 14, 1951, to Jan 15, 1951, that I last saw the deceasedalive on Jan 14, 1951, and that death occurred at 9:10 A.M. from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

1-18-51 Mary W. HollowayAnna A. Buehns Berlin Md

450736

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH COUNTY <i>Wicomico</i> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Maryland</i> COUNTY <i>Worcester</i> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i> | | CITY (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Deer's Head State Hosp.</i> | | STREET ADDRESS (If rural, give location) | |
| 3. NAME OF DECEASED (Type or Print) | (First) <i>Edward</i> | (Middle) <i>Lee</i> | (Last) <i>Timmons</i> |
| 4. DATE OF DEATH | (Month) <i>Jan.</i> | (Day) <i>25</i> | (Year) <i>1951</i> |
| 5. SEX <i>m</i> | 6. COLOR OR RACE <i>W</i> | 7. <input checked="" type="checkbox"/> SINGLE, <input type="checkbox"/> MARRIED, <input type="checkbox"/> WIDOWED, <input type="checkbox"/> DIVORCED, (Specify) | 8. DATE OF BIRTH <i>Oct. 31, 1868</i> |
| 9. AGE last birthday <i>82</i> yrs. | If under 1 year Months | If under 24 hrs. Days | If under 24 hrs. Hours |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>unemployed</i> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) <i>Maryland, Berlin</i> | 12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i> |
| 13. FATHER'S NAME <i>Jenkins Timmons</i> | 14. MOTHER'S MAIDEN NAME <i>Rachel Jarman</i> | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>unknown</i> | |
| 16. SOCIAL SECURITY No. | 17. INFORMANT AND ADDRESS <i>Hospital Record</i> | | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

443x Immediate cause

(a) *Hypertensive Cardiovascular disease*

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c) *Arteriosclerosis, General*

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Aspiration pneumonia

9 days

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Dec. 19, 1950*, to *Jan. 25, 1951*, that I last saw the deceasedalive on *Jan. 25, 1951*, and that death occurred at *2:58 P.M.*, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

1-25-51

Marjorie Holloway

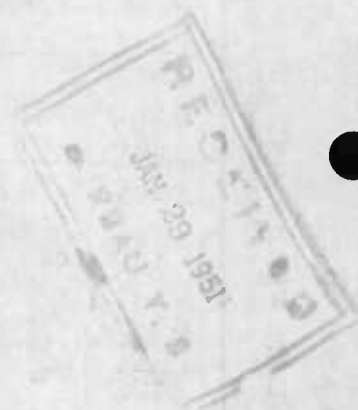
Alleg B. Brown Snow Hill, Md.

VVVVVV

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Evidence for addition
of age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

FILE No. G 130 JAN 16 1951

| | | | |
|--|------------------------------------|--|---|
| 1. PLACE OF DEATH COUNTY <u>Wicomico</u> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY | |
| CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head</u> | | STREET ADDRESS (If rural, give location) <u>107 N. Bond St.</u> | |
| 3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Joseph Thomas Toomer</u> | | 4. DATE OF DEATH (Month) (Day) (Year) <u>1 4 1951</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>colored</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u> | 8. DATE OF BIRTH |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>unk.</u> | 11. BIRTHPLACE (State or foreign country) <u>Georgia</u> |
| 13. FATHER'S NAME <u>Toomer, Joseph</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>240</u> | | 14. MOTHER'S MAIDEN NAME <u>Williams Lennie</u> | |
| 16. SOCIAL SECURITY No. | | 17. INFORMANT AND ADDRESS <u>Hospital Record</u> | |

18. MEDICAL CERTIFICATION

| | | |
|---|---|--|
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
| Immediate cause <u>443X</u> (a) <u>Hypertensive cardiovascular disease</u> | (b) <u>Arteriosclerosis General</u> | <u>Unknown</u> |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>61</u> (c) <u>Diabetes mellitus, uncontrolled</u> | | <u>Unknown</u> |
| 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | <u>Unknown</u> |
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) (COUNTY) (STATE) |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> | HOW DID INJURY OCCUR? |

22. I hereby certify that I attended the deceased from 12/20, 1950, to 1/4/51, 1951, that I last saw the deceased alive on Jan. 4, 1951, and that death occurred at 6:22 A. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Opel C. Paas, M.D. Deer's Head State Hosp, Salisbury, Md. 1/4/51

| | | | |
|--|-------------------------|-------------------------------|--|
| 23. BURIAL CREMATION REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
| <u>Burial</u> | <u>1-7-51</u> | <u>mt Calvary Cem.</u> | <u>Brooklyn Md</u> |
| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
| <u>1-9-51</u> | <u>Mary W. Hallaway</u> | <u>Elroy S. Wilson</u> | <u>1000 Brantley Ave</u> |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 9 1951
BUREAU Y.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1957

| | | | |
|--|--------------------------------|---|--|
| 1. PLACE OF DEATH- COUNTY <u>Wicomico</u> CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Salisbury</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u> | | 2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Wicomico</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> STREET ADDRESS (If rural, give location) <u>Delaware Street</u> | |
| 3. NAME OF DECEASED (Type or Print) | (First) <u>James</u> | (Middle) <u>C</u> | (Last) <u>Van Gieson</u> |
| 6. SEX <u>male</u> | 5. COLOR OR RACE <u>caucas</u> | 7. SINGLE, MARRIED, WIDOWED, -DIVORCED, (Specify) <u>married</u> | 8. DATE OF BIRTH <u>1901</u> |
| 9. AGE last birthday <u>49</u> yrs. | | 4. DATE OF DEATH <u>January 23</u> 1957 | 9. AGE last birthday If under 1 year If under 24 hrs. Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer, factory</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>none</u> | 11. BIRTHPLACE (State or foreign country) <u>Charlotte N.C.</u> |
| 13. FATHER'S NAME <u>unknown</u> | | 14. MOTHER'S MAIDEN NAME <u>unknown</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY No. <u>218-24-7501</u> | |
| 17. INFORMANT AND ADDRESS <u>Stora Vangieson</u> | | 18. MEDICAL CERTIFICATION | |

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

177x Immediate cause (a) metastatic Carcinoma
51b Antecedent cause(s) (b) Carcinoma of Prostate Gland
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

| | | |
|--|---|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) (COUNTY) (STATE) |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> | HOW DID INJURY OCCUR? |

22. I hereby certify that I attended the deceased from Nov, 1950, to Jan 23, 1951, that I last saw the deceased alive on Jan 23, 1951, and that death occurred at 8:30 p.m., from the causes and on the date stated above.

| | | |
|--|--|---|
| SIGNATURE <u>Leed R. Grame M.D.</u> | ADDRESS <u>Salisbury, Md.</u> | DATE SIGNED <u>1-25-51</u> |
| 23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u> | DATE THEREOF <u>1-25-51</u> | NAME OF CEMETERY OR CREMATORY <u>Green Oak Cemetery</u> |
| LOCATION (City, town, or county) (State) <u>Salisbury Md</u> | 24. FUNERAL DIRECTOR <u>Booke M. Wines</u> | ADDRESS <u>Salisbury Md</u> |
| DATE REC'D BY LOCAL REG. <u>1-26-51</u> | REGISTRAR'S SIGNATURE <u>Mary W. Holcomway</u> | |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 29 1961
KBAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 3.32

1008

| | | | |
|---|-------------------------------|---|--|
| 1. PLACE OF DEATH COUNTY <u>McCombs</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> TOWN <u>Salisbury</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>P.B. Hoyt</u> | | 2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD.</u> COUNTY <u>McCombs</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> TOWN <u>Salisbury</u> STREET ADDRESS <u>323 E. Nine St.</u> | |
| 3. NAME OF DECEASED (Type or Print) <u>Shuman</u> (First) <u>William</u> (Middle) <u>Robert</u> (Last) | | 4. DATE OF DEATH <u>Jan. 27</u> (Month) <u>27</u> (Day) <u>51</u> (Year) | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH <u>7/7</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Food Distributor</u> | 9. AGE last birthday <u>73</u> yrs. If under 1 year Months Days Hours Min. |
| 11. BIRTHPLACE (State or foreign country) <u>Chambers Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Shuman Robert</u> | | 14. MOTHER'S MAIDEN NAME <u>Louise Boyman</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) <u>No</u> | | 16. SOCIAL SECURITY No. <u>323 E. Nine St. Salisbury Md.</u> | |
| 17. INFORMANT <u>Mrs. Cora E. Wilster (Wife)</u> | | | |

| | | | | | |
|---|--|---|--|--|--|
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | 18. MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH | |
| Immediate cause (a) <u>Acute cardiac failure (arteriosclerosis)</u> | | | | <u>1 day</u> | |
| Antecedent cause (s) <u>610X</u> | | | | | |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>137a</u> | | (b) <u>Benign hypertrophy prostate.</u> | | | |
| 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | | |
| 19a. DATE OF OPERATION <u>12-18-50</u> | | 19b. MAJOR FINDINGS OF OPERATION <u>Benign Hypertrophy Prostate.</u> | | 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 21. ACCIDENT (Specify) <u>SUICIDE</u> | | PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>Salisbury Md.</u> | | (CITY OR TOWN) (COUNTY) (STATE) | |
| TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u> | | INJURY OCCURRED While at Work <input type="checkbox"/> Not White At work <input type="checkbox"/> | | HOW DID INJURY OCCUR? | |

22. I hereby certify that I attended the deceased from 12-18-50, 1950, to 1-27, 1951, that I last saw the deceased alive on 1-26, 1951, and that death occurred at 8:17a m., from the causes and on the date stated above.

SIGNATURE Flora A. Smith (Degree or title) ADDRESS Salisbury Md. DATE SIGNED 1-29-51

| | | | | | | | | | |
|--|--|---|--|--|--|---|--|---------|--|
| 21. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u> | | DATE <u>Jan. 29-51</u> | | NAME OF CEMETERY OR CREMATORY <u>Parson Ave.</u> | | LOCATION (City, town, or county) <u>Salisbury Md.</u> | | (State) | |
| DATE REC'D BY LOCAL REG. <u>1-29-51</u> | | REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u> | | 24. FUNERAL DIRECTOR <u>Holloway & Co.</u> | | ADDRESS <u>Salisbury Md.</u> | | | |
| | | | | <u>Walter R. Holloway</u> | | <u>970 698</u> | | | |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

| | | | |
|--|---------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH. COUNTY <u>Wicomico</u> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED. STATE <u>Maryland</u> COUNTY <u>Jorchester</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> | |
| TOWN <u>Salisbury</u> | | TOWN <u>Cambridge</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hosp.</u> | | STREET ADDRESS (If rural, give location) <u>Appleby</u> | |
| 3. NAME OF DECEASED (Type or Print) | (First) <u>Reuben</u> | (Middle) <u>Vaughn</u> | (Last) <u>Wheatley</u> |
| 4. DATE OF DEATH | (Month) <u>Jan.</u> | (Day) <u>18</u> | (Year) <u>1957</u> |
| 5. SEX <u>m</u> | 6. COLOR OR RACE <u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH <u>Jan. 28, 1869</u> |
| 9. AGE last birthday <u>81</u> yrs. | | 10. If under 1 year Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>invalid</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Galestown</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Silas Wheatley</u> | | 14. MOTHER'S MAIDEN NAME <u>Elizabeth Vaughn</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u> | | 16. SOCIAL SECURITY No. <u>service</u> | |
| 17. INFORMANT AND ADDRESS <u>Hospital Record</u> | | | |

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Thrombosis of right middle cerebral artery

INTERVAL BETWEEN ONSET AND DEATH 14 yrs.

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c) recurrent

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

| | | | | |
|--|---|-----------------------|----------|---------|
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE) |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> | HOW DID INJURY OCCUR? | | |

22. I hereby certify that I attended the deceased from Jan. 9, 1951, to Jan. 18, 1957, that I last saw the deceased alive on Jan. 18, 1957, and that death occurred at 11:45 A. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

| | | | | |
|---|-------------------------|-------------------------------|----------------------------------|-----------|
| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State) |
| <u>Burial</u> | <u>1/21/57</u> | <u>Salisbury P.M.E.</u> | <u>Galestown</u> | <u>md</u> |
| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS | |
| <u>1-20-57</u> | <u>Mary W. Holloway</u> | <u>Paul J. Smith</u> | <u>Shaptown, Md.</u> | |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF INVESTIGATION

WASHINGTON, D. C. 20535

RECEIVED
JAN 24 1951
FBI - WASH. D. C.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

| | | | |
|--|-----------------------------|--|---------------------------------|
| 1. PLACE OF DEATH- COUNTY <u>Wicomico</u> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Wicomico</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Head-o-the-Creek all life</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Head-o-the-Creek</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>at home</u> | | STREET ADDRESS (If rural, give location) <u>P. O. address Quantico, Md. Rt. #1</u> | |
| 3. NAME OF DECEASED (Type or Print) | (First) <u>Robert</u> | (Middle) <u>Fulton</u> | (Last) <u>Wilson</u> |
| 4. DATE OF DEATH | (Month) <u>1</u> | (Day) <u>8</u> | (Year) <u>1951</u> |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>a a</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u> | 8. DATE OF BIRTH <u>1-20-03</u> |
| 9. AGE last birthday <u>47 yrs.</u> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>merchant</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland Wicomico Co.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | |
| 13. FATHER'S NAME <u>Samuel Benjamin Wilson</u> | | 14. MOTHER'S MAIDEN NAME <u>Annie Eliza Jones</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY No. <u>no</u> | |
| 17. INFORMANT AND ADDRESS <u>Mrs. Juanita Wilson, Quantico, Md. Rt. #1</u> | | | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Cerebral Haemorrhage

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) hypertension

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN ONSET AND DEATH

7 days3 years

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY?

Yes ☐ No ☐

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased

alive on....., 19....., and that death occurred at.....m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Edson S. Mawdsome Princess Anne road Tow 9 51

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

1-12-51 Mary W. Holloway Church Cemetery Head-of-Creek-Head-of-Creek-Wicomico Co. Md. James B. Tashell, Salisbury Maryland

2905 026

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

Reg. Dist. No. 335

| | | | |
|--|-------------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH - COUNTY <u>Wicomico</u> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>MD</u> COUNTY <u>Wicomico</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Sharptown, Md.</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>SHARPTOWN</u> | |
| TOWN <u>SHARPTOWN</u> | | TOWN <u>SHARPTOWN</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>NANTICOLE ST</u> | | STREET ADDRESS (If rural, give location) <u>NANTICOLE ST</u> | |
| 3. NAME OF DECEASED (First) <u>Tieghman</u> (Middle) <u>r</u> (Last) <u>Wright</u> | | 4. DATE OF DEATH (Month) <u>Jan</u> (Day) <u>14</u> (Year) <u>1958</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u> | 8. DATE OF BIRTH <u>Feb 18 1891</u> |
| 9. AGE last birthday <u>59</u> yrs. | | 10. If under 1 year Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Electrician</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>MD</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <u>Henry Wright</u> | | 14. MOTHER'S MAIDEN NAME <u>Elizabeth Ann Willing</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY No. <u>215-04-2028</u> | |
| 17. INFORMANT <u>Mrs. Lea Dickers</u> | | | |

| | |
|---|---|
| 18. MEDICAL CERTIFICATION | |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | |
| Immediate cause (a) <u>Coronary Disease</u> Antecedent cause(s) (b) <u>940 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u> (c) | |
| 2. OTHER SIGNIFICANT CONDITIONS | |
| Conditions contributing to the death but not related to the disease or condition causing death. | |
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION |
| 20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY |
| (CITY OR TOWN) | (COUNTY) |
| (STATE) | |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |
| HOW DID INJURY OCCUR? | |

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE Charles S. Fisher M.D. (Degree or title) ADDRESS 300 N. Division St. Salisbury Md DATE SIGNED 1/14/58

| | | | | |
|--|-----------------------|-------------------------------|---------------------------------|-----------|
| 23. BURIAL, CREMATION OR REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town or county) | (State) |
| <u>Burial</u> | <u>1/17/58</u> | <u>Fleming</u> | <u>Sharptown</u> | <u>MD</u> |
| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS | |
| <u>1/16/58</u> | <u>Walter B. Mann</u> | <u>Paul J. Smith</u> | <u>Sharptown, Md.</u> | |

